enrollment/change/waiver COBRA: If individual is a continuee Qualifying Event __ group insurance form Date of Event ____ Cert. # Policy and Div. # 026-Suffern: MY 1090! Name and Address of Employer (Policyholder) ___ 1 to enroll Dental To terminate all coverages employee information Marital Status Single Married Social Security number _____ Emoloyee's last name, first name, MI Rehlre: Rehire date Full time date of hire _____ Occupation ____ Hours worked each week _____ Are your earnings paid: Hourty or \$\sample\$ \$\sample\$ \$\sample\$ \$\sample\$ Hourty or \$\simple\$ \$\sample\$ City_____ State___ ZIP_____ Street address _____ E-mail address (limit of 60 characters) Are you covered under another dental insurance plan?..... Employee: Yes No Dependents: Yes No dependent coverage information. List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents) date of birth | social security number sex add drop relationship print full legal name (last, first. Mi) please sign (employee/pollcyholder) The certificate provides dental benefits only. Review your certificate carefully. As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I em eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my selay, THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS I am signing up for coverage until the next employered except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records. Policyholder Signature (do not print) Date Employee Signature (do not print) Any person who knowingly and with intent to defraud any insurance company or other reasons files an application for Insurance or statement of claim containing any materially take information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a traudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such yiolation. Dep. Code Employee late entrant date Dependent late entrant date _____ 2 to change ☐ Name change New Name _____ ☐ Add dependent coverage ☐ If due to marriage, what is the date of marriage?______ ☐ If due to birth/adoption, what is the date of event?______ ☐ If due to loss of coverage, date and reason: ______ ☐ If other, the date of event and please explain: _____ Drop dependent coverage Number of dependents still covered: _____ Effective date of drop: _____ ☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Other (please explain)_ 3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION, THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for: myself (does not apply to TRUST policies) spouse only child(ren) only spouse and child(ren)

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Name of insurance company and employer of dependent ___



NY Specials (5-99) Standard

Special Standard Dental Plan Summary	Cristo Rey High School	Out of Network 80%
Coinsurance	Type 1	6 0%
	Type 2	40%
Deductible	Type 3 #50 Calendar Year Type 2 & S Welved Type 1 Par Person	\$75 Calendar Year Type 2 & 3 Waived Type 1 Per Person
Maximum (per person)	1500 Per Calender Year	1500 Per Calendar Year No
Dental Rewards Allowance Waiting Period	Contracted Fee	80 None

Sample Procedure Listing (Current Dental Terminology & American Demail Association,

_	_	-	_	Or other	-		44.00 0.00		t. C. + Comto	4.75	100	25.85
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Routine Entry (1 per 5 months) Cleaning(per 6 months) Fluorida (Chadren 13 and underlin per 6 months)

Space Mainteners (age 15 and under)

Type 2 Enteron X-rest) for 11 months Full Mouth/Purchase 7, tays (1 to 5 years) Sealerts (ego 15 and under)

Restorative Amalgarias Restarative Composites Denture Flapat: Simple Extractions General Amestresis

Endariantias (nonturgical) Complex Extractions

Out of Network

Type 1

Routine Exam(1 per 5 months) Cleaning(1 per 5 months) Fluonde (Children 13 and under/1 per benefit period)

Space Maintainers (age 15 and under)

Type 2

Bittewing X-rays(1 per 11 months) Full Mouth/Penoremic X-rays(1 in 5 years) Sealants (age 15 and under)

Restorative Amaigams Restorative Composites Denture Repair Simple Extractions General Anasthesia

Type 3

Onlays Crowns(1 in 8 years per tooth) Crown Repair Prosthodomics (fixed bridge; removable complete/partial dentures)(1 in 8 years) Endodontics (nonsurgical) Endodontics (surgical) Periodontics (nonsurgical)

Periodontics (surgical)

Complex Extractions

	Employee Percentage of Premium	30.47%	30.47%	30.47%	30.47%
	Rate (Per Month)	14.97	30.24	32.90 107.96	48.17
al/Vision Plan		Employee Total Premium	Employee Total Premium	Employee Total Premium	Employee Total Premium
Ameritas Dental/Vision Plan		Single	aldino v	t mployee w/Child(ren)	Landy