

**GEMSTAR ADD AN EMPLOYEE INSTRUCTIONS AND FORMS FOR THE FOLLOWING STATES:**

**Connecticut  
Maine  
Massachusetts  
New Hampshire  
New Jersey  
Rhode Island  
Vermont**

Use these forms to add an employee to your GemStar group plan.

1. The employer completes the first part of the enrollment form
2. The employee completes and signs the second part of the enrollment form
3. The employer completes and signs the employee change form

Submit completed forms to:

**Symetra Life Insurance Company  
PO Box 545  
Latham, NY 12110**

If you have any questions concerning these forms or adding employees to your group coverage call:

**(800) 561-7374 (toll free)**

**Symetra<sup>SM</sup> Life Insurance Company**  
**GemStar Group Enrollment Card: Return completed form to your employer**

**FOR COMPANY USE ONLY**

Effective Date: \_\_\_/\_\_\_/\_\_\_

Plan Code: \_\_\_\_\_

Group #/ Division \_\_\_\_\_

CPT: \_\_\_\_\_ **SLICA**

**Employer Information (TO BE COMPLETED BY THE EMPLOYER)**

Name and Address of Employer or Organization (if applicable)	Full-Time Hire Date
	Telephone

**Employee Information (PLEASE PRINT CLEARLY)**

I enroll for coverage:  Employee Only  Employee and Spouse  Employee and Child(ren)  Employee and Family

Last Name	First Name	Initial				Birth Date: / /
Address	Telephone Number					Sex: M [ ] F [ ]
City	State	Zip				
<b>LIST ALL YOUR ELIGIBLE DEPENDENTS BELOW</b>						
Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y	Marital Status
Spouse						Married [ ] Single [ ]
Dependent						
Dependent						
Dependent						
Dependent						

**Please note:** If additional dependent information is necessary please attach a separate sheet of paper

1. Does Spouse have a dental plan: Yes  No   
 With whom? \_\_\_\_\_  
 If answer is "Yes", are dependents enrolled under spouses plan? Yes  No
2. Do you claim a tax exemption for all eligible dependents listed above? Yes  No   
 If no, who is not? \_\_\_\_\_
3. All dependent children above over age 18 are full time students. Yes  No   
 If not, who is not? \_\_\_\_\_

By my signature below, I hereby enroll for coverage under Group Dental Insurance Policy LGC-8854 2/04-38300 issued to the Employer's Voluntary Benefit Insurance Trust insured by Symetra Life Insurance Company, Bellevue, Washington. I certify that I have read the applicable Fraud Notice below. I also hereby authorize payroll deductions from my earnings for any contributions required. This Authorization remains in effect until revoked by me in writing.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT FRAUD NOTICES**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**STATE SPECIFIC NOTICES**

**Maine** - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**New Jersey** - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.