Sun Life Financial®

Please send to: Katy Murray
Account Manager
Email: kmurray@usebsg.com
Fax: 585-546-8315

DEPENDENT CERTIFICATION FORM

Nyack- Group K1901173

Please complete Sections A and B, C or D of this form as applicable to ensure that accurate benefit eligibility is determined for your dependent.
Incomplete or illegible forms will be returned to the sender, resulting in delayed processing.

SECTION A: GENERAL INFORMATION *(To be completed by Employee)*

1. Name of Employee (print - last, first & middle initial)

2. Contract I D N umber (Such as SSN)
___ ___ ___ ___ ___ ___ ___ ___ ___

3. Employee's Address (number, street, city, state & zip code)

4. Dependent Name (print- last, first & middle initial)

5. Dependent's Birthdate (mm/dd/year)

6. Dependent's Relationship to Employee
☐ Son ☐ Daughter ☐ Other

7. Dependent's Marital Status
☐ Single ☐ Married

If dependent is married, provide date of marriage (mm/dd/year)

8. Is dependent currently covered under a medical plan?
☐ Yes ☐ No

If Yes, provide name of insurance company

9. Is dependent currently covered under another dental plan?
☐ Yes ☐ No

If Yes, provide name of insurance company

SECTION B: STUDENT DEPENDENT CERTIF I CATION *(To be completed by Employee)*

1. Name of school in which dependent is enrolled

2. Type of school (i.e., college, trade, etc.)

3. Student enrolled
☐ Full-Time ☐ Part-Time ☐ Post-Graduate

_____ Number of Credits

Will the dependent be graduating within 12 months?
☐ **Yes** ☐ **No**

If "Yes," please provide the expected graduation date: _____

Failure to provide the expected graduation date may result in delayed processing and/or termination of dependent coverage.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Employee | Phone Number | Email Address | Date Signed

SEC T I O N C : DISABLED D E P E N DENT C E RT I F I C AT I O N *(To be completed by Physician)*

1. I s dependent now incapable of self-support because of a disability?
☐ Yes ☐ No

2. Dependent's age when disability occurred

3. Nature of disability (please provide a s much detail a s possible)

4. Prognosis (estimate in months or years)

5. N a m e of Primary Care Physician (print or type)

6. Address of Physician (print or type)

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Physician | Date Signed

SECTION D: DEPENDENT NO LONGER ELIGIBLE *(To be completed by Employee)*

PLEASE MAKE INQUIRY WITH YOUR EMPLOYER TO DETERMINE I F YOUR INELIGIBLE DEPENDENT QUALIFIES FOR COBRA COVERAGE.

I ACKNOWLEDGE THAT THE DEPENDENT LISTED ABOVE IS NO LONGER ELIGIBILE FOR BENEFITS AS A DEPENDENT ON MY DENTAL CONTRACT.

Signature of Employee | Ineligible Effective Date | Date Signed