Huntington Union Free School District
Office of the Assistant Superintendent
Finance and Management Services

MEMORANDUM

TO: **All Employees Participating in the Dental Plan**

FROM: **David H. Grackin**

RE: **Finding a Network Provider**

DATE: **December 4, 2009**

Sun Life, your new dental provider effective January 1, 2010, has teamed with Aetna Dental, one of the largest independent national preferred provider networks.

Aetna Providers are included along with the Fitzharris Providers in the network.

To find out if a dentist participates in the Aetna Dental or Fitzharris Network, visit www.Fitzharrisinsurance.com.

Steps to Access Fitzharris and Aetna Providers:

- Go to www.fitzharrisinsurance.com
- Go to Fitzharris & Company
- Click on PPO (Preferred Provider Network)
- Search for Fitzharris Dental Providers self-funded or fully insured, or
- Search for Sun Life/Aetna Dental Providers (fully insured plans)
- Find a Dentist

Questions can be directed to Fitzharris Administrators at 1(800) 321-1336.

DHG/lt
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Huntington Union Free School District
Office of the Assistant Superintendent-Finance and Management Services
MEMORANDUM

TO: **All Employees Participating in the Dental Plan**
FROM: **David H. Grackin**
RE: **Change of Dental Carrier**
DATE: **December 4, 2009**

We are pleased to advise you that we are transferring the dental program to Sun Life effective January 1, 2010. Below is a summary of the plan design that Sun Life is duplicating:

Benefit	**Benefit Amount & Highlights**	
Dental Insurance for You and Your Dependents		
Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable & Customary Charge
Type A Services	100%	100%
Type B Services	80%	80%
Type C Services	50%	50%
Orthodontic Covered Services	50%	50%
Deductibles for:		
Yearly Individual Deductible	$25 for the following Covered Services Combined: Type B; Type C	$25 for the following Covered Services Combined: Type B; Type C
Yearly Family Deductible	$75 for the following Covered Services Combined: Type B; Type C	$75 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	$2,000 for the following Covered Services: Type A; Type B; Type C	$2,000 for the following Covered Services: Type A; Type B; Type C
Lifetime Individual Maximum Orthodontic Covered Services	$1,000	$1,000

You will have the opportunity to use the Aetna Network of Providers along with the Fitzharris Participating Providers. You are always free to select the dentist of your choice. You will still receive benefits if you decide to go to a Non-Participating Provider. However, if you choose a Non-Participating Provider, your out-of-pocket cost may be more. In most cases, going to a Participating Provider for you dental services should reduce your out-of-pocket expenses because these providers generally charge less.

Attached are instructions to find a Network Provider. Dental Booklets will be available in the near future. If you have any questions concerning your coverage, please contact:

FITZHARRIS & CO. INC.
814 Fulton Street
P.O. Box 9182
Farmingdale, NY 11735
1 (800) 321-1336

Note: Please complete the attached Sun Life Enrollment Form and return to:
Lori Brett @Jack Abrams Intermediate School no later than Friday, December 18, 2009
Thank you.

DHG/lt
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Sun Life Financial®

Sun Life and Health Insurance Company (U.S.)*
Fitzharris & Company
P.O. Box 9182, Farmingdale, NY 11735
Phone: 800 635-5661 • Fax: 516 777.5777 or 5778

ENROLLMENT FORM

Group Name:_____ Personnel/Human Resource Name:_____

DENTAL	VISION	EMPLOYMENT DATE	ACCOUNT NUMBER
Effective: ___ / ___ / ___ ☐ Single ☐ Family ☐ Employee / Spouse ☐ Employee / Dependent	**Effective:** ___ / ___ / ___ ☐ Single ☐ Family ☐ Employee / Spouse ☐ Employee / Dependent	___ / ___ / ___	___

Section 1 (Employee Information)

Last Name	First Name	Middle Initial	Sex	Social Security Number	Employee Date of Birth (Mo., Day, Yr.)
			☐ M ☐ F	/ /	

Street Address — Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____

City — State — ZIP Code

Section 2 (Spouse Information)

Spouse Last Name	First Name	Middle Initial	Sex	Social Security Number	Spouse Date of Birth (Mo., Day, Yr.)
			☐ M ☐ F	/ /	

Other Insurance ☐ Yes ☐ No If yes are the dependents listed below also covered through that plan? ☐Yes ☐No

Section 3 (Dependent Information) - If your dependent is handicapped please include Doctor's statement

Name	Sex	Social Security Number	Date of Birth	Full Time Student
Child	☐ M ☐ F	/ /		☐ Yes ☐ No
Child	☐ M ☐ F	/ /		☐ Yes ☐ No
Child	☐ M ☐ F	/ /		☐ Yes ☐ No
Child	☐ M ☐ F	/ /		☐ Yes ☐ No

Section 4 (Change in Status)

		Date of Change
☐ Change to Single Coverage ☐ Change to Family Coverage	Reason:_____	___/___/___
☐ Name Change	Married Name:_____ Maiden Name:_____	___/___/___
☐ Cancellation - I voluntarily cancel my insurance for myself and/or dependents		___/___/___
☐ COBRA Employee (Eligible to continue for 18 months)	Reason:_____	___/___/___
☐ COBRA Dependent (Eligible to continue for 36 months)	Reason:_____	___/___/___
☐ Survivor Coverage *(See guidelines and limitations in your benefit booklet)*		___/___/___
☐ Retiree Coverage Type of Coverage ☐ Single ☐ Family ☐ Other _____		___/___/___

☐ Request to participate - I hereby request to participate in the insurance program and agree to contribute in the appropriate manner, if required.

☐ Waiver of Insurance - I do not wish to participate in the insurance program offered through my employer, and I understand that if I desire to participate in the plan at a later date, my benefits may be denied or reduced. **(BENEFITS CONTRACTED ON A NON-CONTRIBUTORY BASIS CANNOT BE REFUSED.)**

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall be subjected to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

The information provided above is true and correct to the best of my knowledge.

Signature:_____ Date: ___/___/___

COMPLETED BY ADMINISTRATOR

☐ Contributory ☐ Non-Contributory Waiting Period (if applicable): _____

COMMENTS: _____

Carrier Information: _____

*Formerly known as Genworth Life and Health Insurance Company. Sun Life and Health Insurance Company (U.S.) is a member of the Sun Life Financial group of companies.