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.
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:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Amount &amp; Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Insurance for You and Your Dependents</td>
<td>In-Network based on the Maximum Allowed Charge</td>
</tr>
<tr>
<td>Covered Percentage for:</td>
<td>100%</td>
</tr>
<tr>
<td>Type A Services</td>
<td>80%</td>
</tr>
<tr>
<td>Type B Services</td>
<td>50%</td>
</tr>
<tr>
<td>Type C Services</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic Covered Services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductibles for:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yearly Individual Deductible</td>
<td>$25 for the following Covered Services Combined: Type B; Type C</td>
</tr>
<tr>
<td>Yearly Family Deductible</td>
<td>$75 for the following Covered Services Combined: Type B; Type C</td>
</tr>
<tr>
<td>Maximum Benefit:</td>
<td></td>
</tr>
<tr>
<td>Yearly Individual Maximum</td>
<td>$2,000 for the following Covered Services: Type A; Type B; Type C</td>
</tr>
<tr>
<td>Lifetime Individual Maximum Orthodontic Covered Services</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

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.
ENROLLMENT FORM

Group Name: ____________________________ Personnel/Human Resource Name: ____________________________

**DENTAL**
- Effective: ___ / ___ / ___
  - Single
  - Family
  - Employee / Spouse
  - Employee / Dependent

**VISION**
- Effective: ___ / ___ / ___
  - Single
  - Family
  - Employee / Spouse
  - Employee / Dependent

**EMPLOYMENT DATE**
- ___ / ___ / ___

**ACCOUNT NUMBER**
- __________________________

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Section 1 (Employee Information)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Sex</th>
<th>Social Security Number</th>
<th>Employee Date of Birth (Mo., Day, Yr.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ M ☐ F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Marital Status</th>
<th>Sex</th>
<th>Social Security Number</th>
<th>Employee Date of Birth (Mo., Day, Yr.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Single ☐ Married ☐ Widowed ☐ Divorced</td>
<td>☐ M ☐ F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

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Section 2 (Spouse Information)

<table>
<thead>
<tr>
<th>Spouse Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Sex</th>
<th>Social Security Number</th>
<th>Spouse Date of Birth (Mo., Day, Yr.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ M ☐ F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Full Time Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>☐ M ☐ F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td>☐ M ☐ F</td>
<td></td>
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<td>☐ M ☐ F</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td>☐ M ☐ F</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Section 4 (Change in Status)

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

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COMPLETED BY ADMINISTRATOR

☐ Contributory ☐ Non-Contributory

| COMMENTS: |
| Carried information: |

XGR/2049 12/07

*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.