GUARDIAN™

• Please Print clearly and in Black or Blue ink • Please Print in Capital Letters only

# ENROLLMENT/CHANGE FORM
# DENTAL

| Planholder Name (Company Name) | Group Plan Number | Division | Class |
|---|---|---|---|
| | | | |

**PLEASE CHECK APPROPRIATE BOX** ☐ Initial Enrollment/Refusal of Coverage (Complete Sections 3, 4, 6) ☐ Add Employee/Dependents (Complete Sections 1, 3, 5, 6) ☐ Drop/Refuse Coverage (Complete Sections 2, 4, 6) ☐ Information Change (Complete Section 6)

**SECTION 1**

☐ Add Employee ☐ Add Spouse ☐ Add Children

☐ New Hire
☐ Previously refused this coverage
☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Marriage Date ____/____/____
☐ Previously refused this coverage
☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Newborn
☐ Previously refused this coverage
☐ Adoption Date ____/____/____
☐ Loss of Other Coverage (Complete Section 5 if applicable)

**SECTION 2**

(The date of withdrawal cannot be prior to the date this form is completed and signed.)

☐ Drop Employee (Complete Section 4) ☐ Drop Dependents (Complete Section 4)
☐ Termination of Employment * Last Day of Coverage ____/____/____
☐ Retirement *
*Last Day Worked ____/____/____
*Last Day of Coverage ____/____/____
☐ Other ____

**SECTION 3**

**SELECT COVERAGE:** Dependents cannot be enrolled for coverage refused by the employee.

| Dental | Employee | Spouse | Child(ren) |
|---|---|---|---|
| | ☐ | ☐ | ☐ |

(Select One) ☐ Indemnity ☐ PPO ☐ Buy-Up ☐ Pre-Paid ** (Complete Pre-Paid Office # in Section 6)

**SECTION 4**

**REFUSE/DROP COVERAGE:** (See Refusal on back)

| Dental | Employee | Spouse | Child(ren) |
|---|---|---|---|
| | ☐ | ☐ | ☐ |

**I have been offered the above coverages and wish to refuse/drop enrollment for the followng reasons:**

☐ Covered under another insurance plan
☐ Other ____
(additional information may be required)

**SECTION 5**

**LOSS OF OTHER COVERAGE:**

I and/or my dependents were previously covered under another group plan. Loss of coverage was due to:

Termination of Employment ____/____/____
Divorce ____/____/____
Death of Spouse ____/____/____
Term./Expiration of Coverage ____/____/____

**SECTION 6**

| | Add | Drop | Last | First | MI | Sex | Birth Date (MM DD YYYY) | Social Security Number | Pre-Paid Office # (See directory)* |
|---|---|---|---|---|---|---|---|---|---|
| Employee Name | ☐ | ☐ | | | | M F | - - | | |

Street address | City | State | ZIP

Home Phone: ( ) -

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Are you: ☐ Actively at work ☐ Retired ☐ Other ____ (additional information may be required) Occupation/Job Title:

Number of hours worked per week:

Date of Full Time Hire (MM DD YYYY): - -

| | Add | Drop | Last | First | MI | Sex | Student | Birth Date (MM DD YYYY) | Social Security Number | Pre-Paid Office # (See directory) |
|---|---|---|---|---|---|---|---|---|---|---|
| Spouse Name | ☐ | ☐ | | | | M F | Y N | - - | | |
| Child Name | ☐ | ☐ | | | | M F | Y N | - - | | |
| Child Name | ☐ | ☐ | | | | M F | Y N | - - | | |
| Child Name | ☐ | ☐ | | | | M F | Y N | - - | | |
| Child Name | ☐ | ☐ | | | | M F | Y N | - - | | |

**A)** Have you included stepchildren? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No

**B)** Is this your first eligible child? ☐ Yes ☐ No If "no," please list all eligible children above.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

Signature: ____ Date (MM DD YYYY) - -