



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

**ENROLLMENT/CHANGE FORM  
DENTAL**

<b>Planholder Name (Company Name)</b>	<b>Group Plan Number</b>	<b>Division</b>	<b>Class</b>
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**PLEASE CHECK APPROPRIATE BOX**

<p><input type="checkbox"/> <b>Initial Enrollment/Refusal of Coverage</b> (Complete Sections 3, 4, 6)</p> <p><input type="checkbox"/> <b>Add Employee</b></p> <p><input type="checkbox"/> New Hire <input type="checkbox"/> Previously refused this coverage <input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)</p>	<p><input type="checkbox"/> <b>Add Spouse</b></p> <p><input type="checkbox"/> Marriage Date ____/____/____ <input type="checkbox"/> Previously refused this coverage <input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)</p>	<p><input type="checkbox"/> <b>Add Employee/Dependents</b> (Complete Sections 1, 3, 5, 6)</p> <p><input type="checkbox"/> <b>Add Children</b></p> <p><input type="checkbox"/> Newborn <input type="checkbox"/> Previously refused this coverage <input type="checkbox"/> Adoption Date ____/____/____ <input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)</p>	<p><input type="checkbox"/> <b>Drop/Refuse Coverage</b> (Complete Sections 2, 4, 6)</p> <p><input type="checkbox"/> <b>Information Change</b> (Complete Section 6)</p> <p>(The date of withdrawal cannot be prior to the date this form is completed and signed.)</p> <p><input type="checkbox"/> Drop Employee (Complete Section 4)      <input type="checkbox"/> Drop Dependents (Complete Section 4)</p> <p><input type="checkbox"/> Termination of Employment*      Last Day of Coverage ____/____/____</p> <p><input type="checkbox"/> Retirement* *Last Day Worked ____/____/____ *Last Day of Coverage ____/____/____</p> <p><input type="checkbox"/> Other _____</p>
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**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 following 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**

<b>Employee Name</b>	Add Drop Last	First	MI	Sex	Birth Date (MM DD YYYY)	Social Security Number	Pre-Paid Office # (See directory)
<input type="checkbox"/>	<input type="checkbox"/>			M   F			
<b>Street address</b>				<b>City</b>	<b>State ZIP</b>		
Home Phone: (    )    -    -    -    -				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Are you: <input type="checkbox"/> Actively at work <input type="checkbox"/> Retired <input type="checkbox"/> Other _____ (additional information may be required)				Occupation/Job Title: _____			
Number of hours worked per week:    -    -				Date of Full Time Hire (MM DD YYYY):    -    -    -    -			

<b>Spouse Name</b>	Add Drop Last	First	MI	Sex	Student	Birth Date (MM DD YYYY)	Social Security Number	Pre-Paid Office # (See directory)
<input type="checkbox"/>	<input type="checkbox"/>			M   F	Y   N			
<b>Child Name</b>	<input type="checkbox"/>	<input type="checkbox"/>		M   F	Y   N			
<b>Child Name</b>	<input type="checkbox"/>	<input type="checkbox"/>		M   F	Y   N			
<b>Child Name</b>	<input type="checkbox"/>	<input type="checkbox"/>		M   F	Y   N			
<b>Child Name</b>	<input type="checkbox"/>	<input type="checkbox"/>		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)    -    -    -    -

**Refusal of Insurance:**

If the plan requires contributions, and I have refused the insurance, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be considered a late entrant and my dental benefits will be limited for specific periods of time. However, I and/or my dependents will not be subject to late entrant penalties if dental coverage under another plan is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or where a court has ordered coverage be provided for an eligible spouse or eligible minor child(ren), and application for this plan and documentation of the loss of other coverage is received within 31 days of the termination of such coverage.

\*\* The Pre-Paid dental plan refers to (a) DHMO's which are underwritten by Managed Dental Care of California or Managed DentalGuard or; (b) Managed DentalGuard plans underwritten by The Guardian Life Insurance Company of America. Please consult your Plan Administrator for the plan available to you. The late entrant provision does not apply to Pre-Paid dental benefits. Eligibility for this coverage is only available at the open enrollment period.

**Agreement:**

I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for coverage, or agree that the contributions be added to my dues; (3) state that I became an employee, and do currently work the number of hours per week stated on this form. I understand that, in order to be accepted for coverage, my signed and completed application for coverage must be received by Guardian within 31 days of my eligibility for coverage. I authorize any provider, insurer, or other organization to release the necessary information regarding my dental history, treatment or benefits to Guardian or its subsidiary or authorized agent, for the purpose of plan administration.