



• 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 1, 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 (New Hire, Previously refused, Loss of Other Coverage), Add Spouse (Marriage Date, Previously refused, Loss of Other Coverage), Add Children (Newborn, Previously refused, Adoption Date, Loss of Other Coverage). SECTION 2: Drop/Refuse Coverage (Drop Employee, Termination of Employment, Retirement, Last Day Worked, Last Day of Coverage, Other), Information Change (Drop Dependents, Last Day of Coverage).

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: Employee Name, Add Drop Last, First, MI, Sex, Birth Date (MM DD YYYY), Social Security Number, Pre-Paid Office # (See directory), Street address, City, State, ZIP, Home Phone, Marital Status, Are you: Actively at work, Retired, Other, Occupation/Job Title, Number of hours worked per week, Date of Full Time Hire (MM DD YYYY). Spouse Name, Add Drop Last, First, MI, Sex, Student, Birth Date (MM DD YYYY), Social Security Number, Pre-Paid Office # (See directory). Child Name, Add Drop Last, First, MI, Sex, Student, Birth Date (MM DD YYYY), Social Security Number, Pre-Paid Office # (See directory).

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.