



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

ENROLLMENT/CHANGE FORM
DENTAL/VISION

Planholder Name (Company Name) Group Plan Number Division Class

PLEASE CHECK APPROPRIATE BOX Initial Enrollment/Refusal of Coverage Add Employee/Dependents Drop/Refuse Coverage Information Change

SECTION 1 Add Employee Add Spouse Add Children Add Children New Hire Marriage Date Previously refused this coverage Adoption Date Loss of Other Coverage SECTION 2 Drop/Refuse Coverage Information Change

SECTION 3 SELECT COVERAGE(S): Dependents cannot be enrolled for coverage refused by the employee. Dental Employee Spouse Child(ren) Vision Employee Spouse Child(ren)

SECTION 4 REFUSE/DROP COVERAGE(S): (See Refusal on back) Dental Employee Spouse Child(ren) Vision 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

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: Single Married Divorced Legally Separated Widowed 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 Y N Birth Date (MM DD YYYY) Social Security Number Pre-Paid Office # (See directory) Child Name Add Drop Last First MI Sex Y N Birth Date (MM DD YYYY) Social Security Number Pre-Paid Office # (See directory) Child Name Add Drop Last First MI Sex Y N Birth Date (MM DD YYYY) Social Security Number Pre-Paid Office # (See directory) A) Have you included stepchildren? B) Is this your first eligible child?

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 required to furnish, at my own expense, proof of each person's insurability, and Guardian reserves the right to reject my request. Proof of insurability does not apply to dental, but 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; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. 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.