



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

**ENROLLMENT/CHANGE FORM
LIFE/DENTAL/DISABILITY/VISION**

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)

<p>SECTION 1</p> <p><input type="checkbox"/> Add Employee</p> <p><input type="checkbox"/> New Hire</p> <p><input type="checkbox"/> Previously refused this coverage</p> <p><input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)</p>	<p><input type="checkbox"/> Add Spouse</p> <p>Marriage Date ____/____/____</p> <p><input type="checkbox"/> Previously refused this coverage</p> <p><input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)</p>	<p><input type="checkbox"/> Add Children</p> <p><input type="checkbox"/> Newborn</p> <p><input type="checkbox"/> Previously refused this coverage</p> <p><input type="checkbox"/> Adoption Date ____/____/____</p> <p><input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)</p>	<p>SECTION 2</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)</p> <p><input type="checkbox"/> Termination of Employment *</p> <p><input type="checkbox"/> Retirement *</p> <p>*Last Day Worked ____/____/____</p> <p>*Last Day of Coverage ____/____/____</p> <p><input type="checkbox"/> Other _____</p>
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<p>SECTION 3</p> <p>SELECT COVERAGE(S): Dependents cannot be enrolled for coverage refused by the employee.</p> <p><input type="checkbox"/> Life <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> AD&D <input type="checkbox"/> Employee <input type="checkbox"/> Family (includes EE, Sp, Ch)</p> <p><input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Vision <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Long Term Disability (if applicable choose option)</p> <p><input type="checkbox"/> Short Term Disability (if applicable choose option)</p>	<p>SECTION 4</p> <p>SELECT COVERAGE OPTIONS: Choose only one option for each coverage.</p> <p>Dental <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> Buy-Up <input type="checkbox"/> Pre-Paid * * Complete Pre-Paid Office # in Section 6</p> <p>LTD <input type="checkbox"/> Buy-Up <input type="checkbox"/> Flex AbilityGuard \$ ____ (up to 50% of salary)</p> <p>STD <input type="checkbox"/> Buy-Up <input type="checkbox"/> Flex AbilityGuard \$ ____ (up to 50% of salary)</p>	<p>SECTION 4</p> <p>REFUSE/DROP COVERAGE(S):</p> <p><input type="checkbox"/> Life <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> AD&D <input type="checkbox"/> Employee <input type="checkbox"/> Family (includes EE, Sp, Ch)</p> <p><input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Vision <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Long Term Disability</p> <p><input type="checkbox"/> Short Term Disability</p> <p>I have been offered the above coverages and wish to refuse/drop enrollment for the following reasons:</p> <p><input type="checkbox"/> Covered under another insurance plan</p> <p><input type="checkbox"/> Other _____ (additional information may be required)</p>	<p>SECTION 5</p> <p>LOSS OF OTHER COVERAGE:</p> <p>I and/or my dependents were previously covered under another group plan. Loss of coverage was due to:</p> <p>Termination of Employment ____/____/____</p> <p>Divorce ____/____/____</p> <p>Death of Spouse ____/____/____</p> <p>Term./Expiration of Coverage ____/____/____</p>
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SECTION 6

Employee Name	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	- - - -	- - - -	
Street address			City			State	ZIP
Home Phone: () - - - -			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally 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: _____		Annual Salary (nearest dollar): _____		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	<input type="checkbox"/> <input type="checkbox"/>			M F	Y N - -	- - - -	
Child Name	<input type="checkbox"/> <input type="checkbox"/>			M F	Y N - -	- - - -	
Child Name	<input type="checkbox"/> <input type="checkbox"/>			M F	Y N - -	- - - -	
Child Name	<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.

Beneficiary Designation: (Include full proper name and relationship) Name: _____ Relationship: _____

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.