



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

ENROLLMENT/CHANGE FORM
DENTAL/VISION

Participant Name (Company Name) _____ Group Plan Number _____ Division _____ Class _____

PLEASE CHECK APPROPRIATE BOX Initial Enrollment/Refusal of Coverage (Complete Sections 1, 3, 4, 5) 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 Newborn

New Hire Marriage Date: ____/____/____ Previously refused this coverage

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

SECTION 2

Drop Employee (Complete Section 4) Drop Dependents (Complete Section 4)

Termination of Employment* Retirement* Last Day Worked: ____/____/____ Last Day of Coverage: ____/____/____

*Last Day of Coverage

Other _____

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)

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

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 _____ (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: Dep Last _____ First _____ MI Sex _____ Birth Date (MM DD YYYY) _____ Social Security Number _____ Pre-Paid Office # _____ (See directory)

Street address _____ City _____ State ZIP _____

Home Phone: (____) _____-____-____

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): _____

MI Sex Student Birth Date (MM DD YYYY) Social Security Number Pre-Paid Office # (See directory)

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