



GUARDIAN

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 \_\_\_\_\_

295675 10003016

**PLEASE CHECK APPROPRIATE BOX**  Initial Enrollment/Refusal of Coverage (Complete Sections 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)

Add Employee  Add Spouse  Add Children  Drop Employee (Complete Section 4)  Drop Dependents (Complete Section 4)

New Hire  Marriage Date \_\_\_\_/\_\_\_\_/\_\_\_\_  Previously refused this coverage  Previously refused this coverage  Termination of Employment\*  Retirement\*  Last Day of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_

Loss of Other Coverage (Complete Section 5 if applicable)  Loss of Other Coverage (Complete Section 5 if applicable)

*S: (The date of withdrawal cannot be prior to the date this form is completed and signed.)*

**SELECT COVERAGE:** Dependents cannot be enrolled for coverage refused by the employee.

**Dental**  Employee  Spouse  Child(ren)  Child(ren)

**REFUSE/DROP COVERAGE:** (See Refusal on back)

**Dental**  Employee  Spouse  Child(ren)  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)

**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 3**

Employee Name: Add Drop Last \_\_\_\_\_ 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: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Number of hours worked per week: \_\_\_\_\_ Date of Full Time Hire (MM DD YYYY): \_\_\_\_\_

**SECTION 6**

Spouse Name: Add Drop Last \_\_\_\_\_ MI Sex Student Birth Date (MM DD YYYY) \_\_\_\_\_ Social Security Number \_\_\_\_\_ Pre-Paid Office # (See directory) \_\_\_\_\_

Child Name \_\_\_\_\_ MI F Y N \_\_\_\_\_

Child Name \_\_\_\_\_ MI F Y N \_\_\_\_\_

Child Name \_\_\_\_\_ MI F Y N \_\_\_\_\_

Child Name \_\_\_\_\_ MI F Y N \_\_\_\_\_

Child Name \_\_\_\_\_ MI 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) \_\_\_\_\_

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