



**ENROLLMENT/CHANGE FORM  
DENTAL**

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

Planholder Name (Company Name) \_\_\_\_\_ Division \_\_\_\_\_ Class \_\_\_\_\_  
 Group Plan Number \_\_\_\_\_

**PLEASE CHECK APPROPRIATE BOX**  Initial Enrollment/Refusal of Coverage (Complete Sections 3, 4, 6)  Drop/Refuse Coverage (Complete Sections 2, 4, 6)  Information Change (Complete Section 6)

**SECTION 1**

Add Employee  Add Spouse  Add Children

New Hire  Marriage Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Previously refused this coverage  Previously refused this coverage  
 Loss of Other Coverage  Loss of Other Coverage  
 (Complete Section 5 if applicable) (Complete Section 5 if applicable)

Drop Employee (Complete Section 4)  Drop Dependents (Complete Section 4)  
 Termination of Employment  Termination of Employment  
 Retirement  Retirement  
 \*Last Day of Coverage \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ \*Last Day of Coverage \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Other: \_\_\_\_\_ Other: \_\_\_\_\_

**SECTION 2**

**REFUSE/DROP COVERAGE:** (See Refusal on back)  
 Dental  Employee  Spouse  Child(ren)

I have been offered the above coverage and wish to refuse/  
 drop enrollment for the following reasons:  
 Covered under another insurance plan  
 Other \_\_\_\_\_ (additional information may be required)

**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**

**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 5**

**REFUSE/DROP COVERAGE:** (See Refusal on back)  
 Dental  Employee  Spouse  Child(ren)

I have been offered the above coverage and wish to refuse/  
 drop enrollment for the following reasons:  
 Covered under another insurance plan  
 Other \_\_\_\_\_ (additional information may be required)

**SECTION 6**

**EMPLOYEE INFORMATION**

Employee Name: \_\_\_\_\_ 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**

Date of Full Time Hire (MM DD YYYY): \_\_\_\_\_ Pre-Paid Office # (See directory) \_\_\_\_\_

**DEPENDENT INFORMATION**

Add Dep Last \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Student \_\_\_\_\_ Birth Date (MM DD YYYY) \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 First \_\_\_\_\_ M F Y N

Spouse Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Student \_\_\_\_\_ Birth Date (MM DD YYYY) \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 First \_\_\_\_\_ M F Y N

Child Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Student \_\_\_\_\_ Birth Date (MM DD YYYY) \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 First \_\_\_\_\_ M F Y N

Child Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Student \_\_\_\_\_ Birth Date (MM DD YYYY) \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 First \_\_\_\_\_ M F Y N

Child Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Student \_\_\_\_\_ Birth Date (MM DD YYYY) \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 First \_\_\_\_\_ 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.

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) \_\_\_\_\_

KEEP A COPY FOR YOUR RECORDS AND SEND A COPY TO THE PERSON MAKING THE ELECTION.

Signature of Person Electing Continuation Date		Certified for Planholder By (Name and Title) Date	
<p>You must advise the planholder, in writing, in the event you are no longer eligible for continuation or you no longer wish to continue coverage.</p> <p>Please continue coverage for:</p> <p>Employee: <input type="checkbox"/> Employee &amp; Eligible Dependents: <input type="checkbox"/> Major Medical: <input type="checkbox"/> Dental: <input type="checkbox"/> Vision: <input type="checkbox"/> Stand Alone RX: <input type="checkbox"/></p> <p>Spouse: <input type="checkbox"/> Spouse &amp; Child(ren): <input type="checkbox"/> Major Medical: <input type="checkbox"/> Dental: <input type="checkbox"/> Vision: <input type="checkbox"/> Stand Alone RX: <input type="checkbox"/></p> <p>Child(ren): <input type="checkbox"/> Major Medical: <input type="checkbox"/> Dental: <input type="checkbox"/> Vision: <input type="checkbox"/> Stand Alone RX: <input type="checkbox"/></p>			
<p><input type="checkbox"/> I do not elect to continue my medical/dental/vision coverage under the Group Plan and agree to the conditions and requirements outlined above.</p> <p><input type="checkbox"/> I elect to continue my medical/dental/vision coverage under the Group Plan.</p> <p>(Note: In most instances, Medicare benefits will be primary for individuals entitled to COBRA.)</p>			
<p><b>PLEASE READ THE CERTIFICATE BOOKLET FOR ADDITIONAL INFORMATION</b></p> <p>In addition, you may exercise any hospital and/or medical continuation rights now or at the end of the continuation period. Life insurance does not apply to, or is restricted by, the individual because of portability of coverage; (5) the date the individual becomes entitled to Medicare. Continued coverage will end on the earliest of the following events to occur: (1) the end of the period of continuation for which the individual is entitled; (2) the date the employer ceases to provide a group plan to any employee; (3) the expiration of the monthly period for which premiums have been paid; (4) the date the individual becomes covered under a group plan which does not contain any exclusion or limitation with respect to a pre-existing condition of the person (other than an exclusion or limitation which does not apply to, or is restricted by, the individual because of portability of coverage); (5) the date the individual becomes entitled to Medicare. Continuation is not available after the 60 days have elapsed. The first monthly premium must be paid 45 days from the date the individual signs the election form. The planholder should mail or fax the completed form to Guardian.</p> <p>When an individual's group coverage terminates, the planholder must notify the individual within 14 days of the right to continue coverage. If this is not possible, the form should be mailed to the individual's last known address. The completed form must be returned to the planholder within 60 days of notification. If it is not returned within that time, it is assumed the individual has elected not to continue under the group plan. Amount may change in accordance with any premium rate changes for the group plan.</p> <p>In order to retain your insurance benefits under the group plan, you will be required to pay the full monthly premium to the planholder. This amount may change in accordance with any premium rate changes for the group plan.</p> <p>Group insurance benefits and premium rates for individuals on continuation are the same as those for active employees and dependents. The planholder may charge an additional 2% of premium as an administrative fee. For those disabled individuals who extend coverage from 18 to 28 months, or family members who continue with such individuals, the planholder may charge an additional 50% of premium for the 18th through the 28th month. Any change in benefits will apply to persons with continued coverage, provided they are not hospitalized at the time.</p> <p>Under Federal law, when group coverage terminates due to a reduction of work hours or termination of employment other than for gross misconduct, the law permits continuation of Medical, Dental, Vision and Stand Alone Prescription Drug coverage for employees and/or insured dependents for up to 18 months. A spouse or child who loses coverage due to an employer's death, divorce, legal separation or entitlement to Medicare and a child who loses dependent status under the plan may elect continuation for up to 36 months. If a child is born to, or placed for adoption with, a covered employee during a period of continuation, that child may be added to the continued coverage. An individual who is determined to be totally disabled under the Social Security Act at any time during the first 60 days of continued coverage, or a family member of the individual, may extend coverage from 18 to 28 months if the determination is provided before the end of the 18 month period. When it is determined under the Social Security Act that the individual is no longer disabled, continuation beyond 18 months will end in the month that begins more than 30 days after the determination. An individual's Life, Accidental Death and Dismemberment and Disability Income Insurance may not be continued.</p>			
<p>Reason for Loss of Coverage (Check one)</p> <p><input type="checkbox"/> Termination of Employment <input type="checkbox"/> Legal Separation <input type="checkbox"/> Child Losing Dependent Status</p> <p><input type="checkbox"/> Reduction of Work Hours <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Employee</p> <p>Date of Last Coverage: _____ For Guardian Use Only</p>			
<p>Expiration (if necessary)</p>			
<p>Home Address:</p>			
<p>Full Name (Last, First, MI) _____</p> <p>Sex _____ Date of Birth _____ Relationship to Employee _____</p>			
<p>Names of Continuing Eligible Dependents (if more space is needed please attach a separate sheet of paper)</p>			
<p>Name of Insured Employee (Last, First, MI) _____ Social Security # _____ Date of Birth _____ Class _____</p>			
<p>Planholder Address _____</p>			
<p>Planholder Name _____ Group Plan # _____ Date _____</p>			

