GUARDIAN® The Guardian Life Insurance Company of America

Wholly Owned Subsidiaries:
(see paragraph "Pre-Paid Dental" on reverse side)
Managed Dental Care (MDC) (CA)
Managed DentalGuard (MDG) (TX, NJ)
First Commonwealth (FCW) (IL, MO, IN, WI) (For Plans in MI see (h) on reverse side)

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

ENROLLMENT/CHANGE FORM DENTAL

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)

SECTION 1

☐ Add Employee
☐ New Hire
☐ Previously refused this coverage
☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Spouse
☐ Marriage Date ____/____/____
☐ Previously refused this coverage
☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Children
☐ Newborn
☐ Previously refused this coverage
☐ Adoption Date ____/____/____
☐ Loss of Other Coverage (Complete Section 5 if applicable)

SECTION 2

☐ Drop Employee (Complete Section 4) ☐ Drop Dependents (Complete Section 4)
The date of withdrawal cannot be prior to the date this form is completed and signed.
☐ Termination of Employment*
☐ Retirement
Last Day Worked ____/____/____
Last Day of Coverage ____/____/____
☐ Other ____________

SECTION 3

SELECT COVERAGE: Dependents can only be enrolled in the same coverages as selected by the employee.

Dental — Employee ☐ Spouse ☐ Child(ren) ☐

(Select One) ☐ Indemnity ☐ PPO ☐ Buy-Up ☐ DNO
☐ Pre-Paid (MDC; MDG; FCW) (PPO; DHMO)
(You must select a primary care dental office for the Pre-Paid Dental option. Complete Pre-Paid Dental Office # in Section 6)

SECTION 4

REFUSE/DROP COVERAGE: (See Refusal on back)

Dental — 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 and/or coverage
☐ 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

Emp. Name | Add ☐ Drop ☐ | Last | First | MI | Sex M F | Birth Date (MM DD YYYY) | Social Security Number | Pre-Paid Dental Office # (See directory)

Street address | City | State | ZIP

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

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):

	Add	Drop	Last	First	MI	Sex	Student	Birth Date (MM DD YYYY)	Social Security Number	Pre-Paid Dental Office # (See directory)
Spouse Name	☐	☐				M F				
Child Name	☐	☐				M F	Y N			
Child Name	☐	☐				M F	Y N			
Child Name	☐	☐				M F	Y N			
Child Name	☐	☐				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. C) What is your primary language? D) Do you have a disability which would affect your ability to communicate or read? ☐ Yes ☐ No

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature: ______________________ Date (MM DD YYYY)