GUARDIAN®

ENROLLMENT/CHANGE FORM

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

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(S): Dependents cannot be enrolled for coverage refused by the employee.

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

SELECT COVERAGE OPTIONS: Choose only one option for each coverage.

Dental ☐ PPO ☐ Pre-Paid *

SECTION 4

REFUSE/DROP COVERAGE(S):

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

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

Street address | City | State | ZIP

Home Phone: ( ) -

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

Are you: ☐ Actively at work ☐ Retired ☐ 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): - -

	Add ☐ Drop ☐ Last	First	MI	Sex	Student	Birth Date (MM DD YYYY)	Social Security Number	Pre-Paid 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.

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) - -