



GUARDIAN DENTAL Enrollment Form

Please check reason for completing this form

<input type="checkbox"/> New Enrollment <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Reinstatement Effective Date: / /	If this is a Change, please indicate type of Change and reason below.				
	<input type="checkbox"/> Cancel Employee <input type="checkbox"/> Termination <input type="checkbox"/> Other - Reason:	<input type="checkbox"/> Add Dependents <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Other - Reason:	<input type="checkbox"/> Cancel Dependent(s) <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Change in Student Status <input type="checkbox"/> Other - Reason:	<input type="checkbox"/> Address Change <input type="checkbox"/> Name Change	<input type="checkbox"/> Transfer to COBRA Qualifying Event <input type="checkbox"/> Termination <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Dep. Status Change <input type="checkbox"/> Other - Reason:

Employer Information - To Be Completed By Employer

Employer Name: Town of Greenfield	Employee's Date of Hire:	Location Code: Town 0000 School 0001 FHETC 0003	Location:	Scheduled Weekly Hrs:
Guardian Dental 357735	Job Title		Department	

Employee Information

Employee Name: Last	First	M.I.	Social Security #	Home Phone:	Work Phone:
Address: Street	Apt.	City	State	Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
					Gender:

Dental Selection Or Waiver - Guardian

Dental Coverage

<input type="checkbox"/> WAIVE COVERAGE	<input type="checkbox"/> Employee <input type="checkbox"/> Emp. + Spouse <input type="checkbox"/> Emp. + Children <input type="checkbox"/> Emp. + Family
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Employee & Dependent Information (Identify yourself and any dependents you want covered, dropped or changed for Medical)

Name (Last, First, MI)	Plan	Drop Add	Sex	FT Student	Birth Date	Soc. Sec. #
Self	<input type="checkbox"/> Dental	<input type="checkbox"/> Drop <input type="checkbox"/> Add	<input type="checkbox"/> M <input type="checkbox"/> F			
Spouse	<input type="checkbox"/> Dental	<input type="checkbox"/> Drop <input type="checkbox"/> Add	<input type="checkbox"/> M <input type="checkbox"/> F			
Child	<input type="checkbox"/> Dental	<input type="checkbox"/> Drop <input type="checkbox"/> Add	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		
Child	<input type="checkbox"/> Dental	<input type="checkbox"/> Drop <input type="checkbox"/> Add	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		
Child	<input type="checkbox"/> Dental	<input type="checkbox"/> Drop <input type="checkbox"/> Add	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N		

Other Insurance Coverage

Are you or your dependents covered by other group dental coverage? Yes No If yes, please complete the following information.

Name of Person	Employer Name,	Insurance Co.Name,	Type of Coverage	Policy Number
			<input type="checkbox"/> Dental	

DENTAL DISCLAIMER: If you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

FRAUD STATEMENT: Any person who with intent to defraud or knowing that he/she 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.

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

- Apply for the benefits designated for which I am eligible under my employer's plan with Health New England, Guardian and my employer's Section 125 Cafeteria Plan.
- Represent that all of the information on this Enrollment/Change Form is complete, correct and true.
- Agree that a photocopy of this Enrollment/Change Form shall be considered to be valid and effective as the original.
- Understand that if I have waived enrollment in any benefits for which I am eligible, and later wish to apply for the benefits I have waived, my application for enrollment in those benefits may be declined, or I may have to furnish at my own expense, evidence of insurability which is satisfactory to the Insurance Companies and my Employer.
- Authorize any required deductions from my earnings.
- Understand that I must meet all the eligibility requirements of my employer's plans to remain insured.

Employee Signature: _____ Date: _____

Authorized Employer Signature: _____ Date: _____

Internal Use Only

Census	<input type="checkbox"/> _____	Sent Guardian	<input type="checkbox"/> _____	Payroll	<input type="checkbox"/> _____	COBRA spreadsheet	<input type="checkbox"/> _____
WebCOBRA	<input type="checkbox"/> _____	Town Ret .	<input type="checkbox"/> _____	Ret. Teacher	<input type="checkbox"/> _____	(ck reason above in changes)	