

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)

<p>SECTION 1</p> <input type="checkbox"/> Add Employee <input type="checkbox"/> New Hire <input type="checkbox"/> Previously refused this coverage <input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)	<input type="checkbox"/> Add Spouse Marriage Date ____/____/____ <input type="checkbox"/> Previously refused this coverage <input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)	<input type="checkbox"/> Add Children <input type="checkbox"/> Newborn <input type="checkbox"/> Previously refused this coverage <input type="checkbox"/> Adoption Date ____/____/____ <input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)	<p>SECTION 2</p> <input type="checkbox"/> Drop Employee (Complete Section 4) The date of withdrawal cannot be prior to the date this form is completed and signed. <input type="checkbox"/> Termination of Employment* <input type="checkbox"/> Retirement Last Day Worked ____/____/____ Last Day of Coverage ____/____/____ <input type="checkbox"/> Other _____
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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) (PPD; 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	Birth Date (MM DD YYYY)	Social Security Number	Pre-Paid Dental Office # (See directory)
<input type="checkbox"/>	<input type="checkbox"/>				M F	- - - -	- - - -	
		Street address			City		State ZIP	
		Home Phone: () -		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed				
		Are you: <input type="checkbox"/> Actively at work <input type="checkbox"/> Retired <input type="checkbox"/> Other _____ (additional information may be required)			Occupation/Job Title: _____			
		Number of hours worked per week: _____		Date of Full Time Hire (MM DD YYYY): - - - -				
Spouse Name	Add Drop	Last	First	MI	Sex	Student Birth Date (MM DD YYYY)	Social Security Number	Pre-Paid Dental Office # (See directory)
<input type="checkbox"/>	<input type="checkbox"/>				M F	- - - -	- - - -	
Child Name	Add Drop	Last	First	MI	Sex	Y N	Birth Date (MM DD YYYY)	Social Security Number
<input type="checkbox"/>	<input type="checkbox"/>				M F	- - - -	- - - -	
Child Name	Add Drop	Last	First	MI	Sex	Y N	Birth Date (MM DD YYYY)	Social Security Number
<input type="checkbox"/>	<input type="checkbox"/>				M F	- - - -	- - - -	
Child Name	Add Drop	Last	First	MI	Sex	Y N	Birth Date (MM DD YYYY)	Social Security Number
<input type="checkbox"/>	<input type="checkbox"/>				M F	- - - -	- - - -	

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) - - - -

Refusal of Insurance and/or Coverage:

If the plan requires contributions, and I have refused the insurance and or coverage, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be considered a late entrant and my dental benefits will be limited for specific periods of time. However, I and/or my dependents will not be subject to late entrant penalties if dental coverage under another plan is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or where a court has ordered coverage be provided for an eligible spouse or eligible minor child(ren), and application for this plan and documentation of the loss of other coverage is received within 31 days of the termination of such coverage. Neither proof of insurability nor the late entrant provision apply to Pre-Paid dental benefits.

Pre-Paid Dental:

The Pre-Paid Dental plan refers to, as applicable, (a) Managed DentalGuard dental HMO plans underwritten by Managed Dental Care (in CA) or Managed DentalGuard, Inc. (in TX); or (b) Managed DentalGuard plans underwritten by Managed DentalGuard, Inc. (in NJ); or (c) Managed DentalGuard plans underwritten by The Guardian Life Insurance Company of America (in FL or in NY); or (d) First Commonwealth Insurance Company (in IL); or (e) First Commonwealth of Missouri (in MO); or (f) First Commonwealth Limited Health Service Corporation (in IN and in WI); or (g) In Michigan, First Commonwealth, Inc. underwritten by Capitol Indemnity Corporation (not a wholly owned subsidiary of Guardian). Eligibility for this coverage is only available at the open enrollment period.

Agreement:

I hereby (1) request coverage for the Group Insurance and/or coverage for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for coverage, or agree that the contributions be added to my dues; (3) state that I became an employee, and do currently work the number of hours per week stated on this form. I understand that, in order to be accepted for coverage, my signed and completed application for coverage must be received by Guardian within 31 days of my eligibility for coverage. I authorize any provider, insurer and/or HMO, or other organization to release the necessary information regarding my dental history, treatment or benefits to Guardian or its subsidiary or authorized agent, for the purpose of plan administration.