



**GUARDIAN™**  
 Midwest Regional Office  
 P.O. Box 8013  
 Appleton, WI 54913-8013

**DENTAL INSURANCE  
 Group Insurance Enrollment  
 and Record Form**

PLANHOLDER NAME (COMPANY NAME)		GROUP PLAN NUMBER		BRANCH	
PLANHOLDER STREET ADDRESS			CITY	STATE	ZIP CODE
EMPLOYEE'S NAME (LAST, FIRST, MI)		SOCIAL SECURITY NUMBER	BIRTH DATE	SEX: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
EMPLOYEE'S STREET ADDRESS		CITY	STATE	ZIP	TELEPHONE NUMBER ( ) -
OCCUPATION / JOB TITLE		DATE OF FULL TIME HIRE	HRS WORKED / WEEK	ANNUAL SALARY \$	
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED			DEPENDENT CHILDREN? <input type="checkbox"/> YES <input type="checkbox"/> NO		

**ENROLLMENT FOR INSURANCE (Check appropriate box.)**

<b>EMPLOYEE COVERAGE/S REQUESTED:</b> <input type="checkbox"/> Dental	<b>DEPENDENT COVERAGE/S REQUESTED:</b> (Dependents cannot be enrolled for coverages declined by employee): <input type="checkbox"/> Dental
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**I ELECT DEPENDENT COVERAGE/S FOR MY:**  spouse only  spouse & child(ren)  child(ren) only

LIST EACH DEPENDENT NAME (LAST, FIRST, MIDDLE INITIAL)	SEX	RELATIONSHIP	BIRTH DATE	STUDENT
	<input type="checkbox"/> F <input type="checkbox"/> M			<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> F <input type="checkbox"/> M			<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> F <input type="checkbox"/> M			<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> F <input type="checkbox"/> M			<input type="checkbox"/> YES <input type="checkbox"/> NO

Have you included stepchildren as dependents?  YES  NO If "yes" indicate name/s \_\_\_\_\_  
 Do your stepchildren reside with you?  YES  NO  
 Are they dependent upon you for support and maintenance?  YES  NO

**REFUSAL OF INSURANCE (Complete only if not enrolling for Guardian dental coverages.)**

If the plan required contributions, and I have refused the insurance, I understand that if I request coverage for myself and / or my eligible dependents at a later date, late entrant penalties will apply. (Fill out waiver section only if **CONTRIBUTORY**.)

<b>EMPLOYEE:</b> I decline the dental coverage available to me because:  <input type="checkbox"/> I am insured by: Insurance Carrier Name _____; or  <input type="checkbox"/> Other reasons	<b>DEPENDENT/S</b> I decline the dental coverage available to my <input type="checkbox"/> spouse only <input type="checkbox"/> spouse & child(ren) <input type="checkbox"/> child(ren) only <b>because:</b> <input type="checkbox"/> they are insured by: Insurance Carrier Name _____; or <input type="checkbox"/> Other reasons
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I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the insurance; and (3) state that I became an employee on the date stated above, and do currently work the number of hours per week stated 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 is guilty of insurance fraud. I have reviewed the statements on this application and they are true and complete.

<b>X</b>	SIGNATURE OF WITNESS (only required if employee signature is "X")	DATE
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<b>FOR GUARDIAN USE ONLY</b> (Indicate coverages and amounts)	Employee: Cert No.    Class    Eff. Date <input type="checkbox"/> Dental	DEPENDENT: <input type="checkbox"/> Dental
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