

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	<input type="checkbox"/> Add Employee	<input type="checkbox"/> Add Spouse	<input type="checkbox"/> Add Children	SECTION 2	<input type="checkbox"/> Drop Employee (Complete Section 4)	<input type="checkbox"/> Drop Dependents (Complete Section 4)	
	<input type="checkbox"/> New Hire	<input type="checkbox"/> Marriage Date ____/____/____	<input type="checkbox"/> Newborn		The date of the withdrawal cannot be prior to the date this form is completed and signed		
	<input type="checkbox"/> Previously refused this coverage	<input type="checkbox"/> Previously refused this coverage	<input type="checkbox"/> Previously refused this coverage		<input type="checkbox"/> Termination of Employment*		
<input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)			<input type="checkbox"/> Adoption Date ____/____/____	<input type="checkbox"/> Retirement		<input type="checkbox"/> Last Day Worked ____/____/____	
			<input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)	<input type="checkbox"/> Last Day of Coverage ____/____/____		<input type="checkbox"/> 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 Dental (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 plan.

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 _____

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: _____ Date of Full Time Hire (MM DD YYYY) _____

Spouse Name Add Drop Last _____ First _____ MI _____ Sex M F Student Student Birth Date (MM DD YYYY) _____ Social Security Number _____ Pre-Paid Dental Office # (See directory) _____

Child Name Add Drop Last _____ First _____ MI _____ Sex M F Y N Birth Date (MM DD YYYY) _____ Social Security Number _____ Pre-Paid Dental Office # (See directory) _____

Child Name Add Drop Last _____ First _____ MI _____ Sex M F Y N Birth Date (MM DD YYYY) _____ Social Security Number _____ Pre-Paid Dental Office # (See directory) _____

Child Name Add Drop Last _____ First _____ MI _____ Sex M F Y N Birth Date (MM DD YYYY) _____ Social Security Number _____ Pre-Paid Dental Office # (See directory) _____

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, with intent to defraud or knowing that he is facilitating a fraud against an insurer and/or HMO 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 to provisions on the reverse side of this form which I have read and understand.**

Signature: _____ Date (MM DD YYYY) _____

GG-014289 Effective Date: _____ Department # _____

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 the dental coverage under another plan is being discontinued as a result of termination of another plan's coverage, loss of employment, death of a 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 the other coverage is received within 31 days of the termination of such coverage. Neither proof of insurability nor the late entrant provision apply to Pe-Paid dental benefits.

Pre-Paid Dental:

* The Pre-Paid Dental plan refers to (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 pans 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); and (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 the 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.