GUARDIAN®

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

ENROLLMENT/CHANGE FORM DENTAL

Planholder Name (Company Name)	Group Plan Number	Division	Class
CHRISTIAN RESEARCH INSTITUTE	385805	000101	

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

(The date of withdrawal cannot be prior to the date this form is completed and signed.)

☐ Drop Employee (Complete Section 4)
☐ Termination of Employment *
☐ Retirement *
*Last Day Worked _____/_____/_____
*Last Day of Coverage _____/_____/_____
☐ Other _____

☐ Drop Dependents (Complete Section 4)
Last Day of Coverage _____/_____/_____

SECTION 3

SELECT COVERAGE: Dependents cannot be enrolled for coverage refused by the employee.

Dental	Employee	Spouse	Child(ren)
	☐	☐	☐

(Select One) ☐ Indemnity ☐ PPO ☐ Buy-Up ☐ Pre-Paid ** (Complete Pre-Paid 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

☐ 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

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

Street address _____ City _____ State _____ ZIP _____

Home Phone: ( ) -

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ 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): - -

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.

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) - -

Refusal of Insurance:
If the plan requires 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, 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.

** The Pre-Paid dental plan refers to (a) DHMO's which are underwritten by Managed Dental Care of California or Managed DentalGuard or; (b) Managed DentalGuard plans underwritten by The Guardian Life Insurance Company of America. Please consult your Plan Administrator for the plan available to you. The late entrant provision does not apply to Pre-Paid dental benefits. Eligibility for this coverage is only available at the open enrollment period.

Agreement:
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 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, 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.