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| **A picture containing sitting, dark, computer, computer  Description automatically generatedEnrollment/Change Form*****DENTAL & VISION INSURANCE*** Underwritten by National Guardian Life Insurance Company**Administered by: TPA Name****PO Box 75372****Cincinnati, OH 45275****Please print and complete all sections.** |
| **GROUP/EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)** |  |
| Group/Policyholder Name      | **Group Number** | Location       | Effective Date       | Date of Hire      |
| [ ]  A[ ]  T[ ]  C | Sex[ ]  M[ ]  F | **Last Name**  | First Name      | **M.I.** | **Date of Birth** | Social Security Number      |
| Home Street Address | City/State/Zip      | Home Phone**(****)**  | **Work Phone** **(     )** |
| E-mail Address      | Cell Phone**(     )** |
| **FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (Enroll) T: Terminate C: Change (Change of name or coverage)** |
| [ ]  A[ ]  T[ ]  C | Sex[ ]  M[ ]  F | **Last Name (Spouse )** | First Name | **M.I.** | **Date of Birth** |  |
| [ ]  A[ ]  T[ ]  C | Sex[ ]  M[ ]  F | **Last Name (Dependent)** | **First Name** | **M.I.** | **Date of Birth** | **Child handicapped?****[ ] Yes** **[ ] No** |
| [ ]  A[ ]  T[ ]  C | Sex[ ]  M[ ]  F | **Last Name (Dependent)** | **First Name** | **M.I.** | **Date of Birth** | **[ ] Yes [ ] No**  |
| [ ]  A[ ]  T[ ]  C | Sex[ ]  M[ ]  F | **Last Name (Dependent)** | **First Name** | **M.I.** | **Date of Birth** | **[ ] Yes [ ] No** |
| [ ]  A[ ]  T[ ]  C | Sex[ ]  M[ ]  F | **Last Name (Dependent)** | **First Name** | **M.I.** | **Date of Birth** | **[ ] Yes [ ] No** |
| [ ]  A[ ]  T[ ]  C | Sex[ ]  M[ ]  F | **Last Name (Dependent)** | **First Name** | **M.I.** | **Date of Birth** | **[ ] Yes [ ] No** |

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| **I elect the following coverage(s):** |
|  |
| [ ] Dental | [ ] Vision |
| [ ]   | $      | [ ]   | $      |
| [ ]   | $      | [ ]   | $      |
| [ ]  | $      | [ ]  | $      |
| [ ]   | $      | [ ]   | $      |
| [ ] Waived due to other coverage |  | [ ] Waived due to other coverage |  |
| [ ] Waive |  | [ ] Waive |  |
| **Do you or any of your dependents have other dental or vision insurance?** **[ ]  Yes** **[ ]  No**If yes, please give: Policyholder and Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION TO OBTAIN INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.