|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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.