Enrollment/Change Form

DENTAL & VISION INSURANCE

Underwritten by National Guardian Life Insurance Company

P.O. Box 1424 Milwaukee, WI 53201

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	First Name	M.I.	Date of Birth	
☐ 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

NOTE for Dental: Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage, may be subject to additional limitations or waiting periods upon enrolling.

NOTE for Vision: Members that waive coverage at initial enrollment or in the new eligibility period and/or terminate coverage, may be subject to additional benefit limitations, upon enrolling.

I elect the following coverage(s):

☐Dental
- ☐Employee Only $____
- ☐Employee + Spouse $____
- ☐Employee + Child(ren) $____
- ☐Employee Family $____
- ☐Waived due to other coverage
- ☐Waive

☐Vision
- ☐Employee Only $____
- ☐Employee + Spouse $____
- ☐Employee + Child(ren) $____
- ☐Employee Family $____
- ☐Waived due to other coverage
- ☐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.