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
LEGAL SERVICES NYC	G291131		

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 ____/____/____

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

☐ Other ____

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

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

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):

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

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)