

GUARDIAN CHECKLIST OF ITEMS TO COMPLETE & RETURN

DENTAL INSURANCE

Enrollment & Participation Form

Enrollment Form for Non-Medical Coverage

Tax Documentation: Most Recent Quarterly NYS-45

Any questions on completing forms contact:
Adirondack Regional Chamber of Commerce

5 Warren St.

Glens Falls, NY 12801

518-798-1761

518-792-4147 (fax)

www.adirondackchamber.org

(Revised 3/6/08)





GUARDIAN

Planholder Name (Company Name)

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

ENROLLMENT/CHANGE FORM
DENTAL

Group Plan Number Division Class

PLEASE CHECK APPROPRIATE BOX Initial Enrollment/Refusal of Coverage (Complete Sections 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 Add Spouse Add Children Newborn Previously refused this coverage Adoption Date ____/____/____ Loss of Other Coverage (Complete Section 5 if applicable) Marriage Date ____/____/____ Previously refused this coverage Drop Employee (Complete Section 4) Termination of Employment* Retirement* Last Day of Coverage ____/____/____ Drop Dependents (Complete Section 4) Last Day of Coverage ____/____/____

SECTION 2

Add Children Newborn Previously refused this coverage Adoption Date ____/____/____ Loss of Other Coverage (Complete Section 5 if applicable) Marriage Date ____/____/____ Previously refused this coverage Drop Employee (Complete Section 4) Termination of Employment* Retirement* Last Day of Coverage ____/____/____ 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) 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 MI Sex M F Birth Date (MM DD YYYY) Social Security Number Pre-Paid Office # (See directory)

Street address _____ City _____ State ZIP _____

Home Phone: (____) _____

Are you: Actively at work Retired Other _____ (additional information may be required) Occupation/Job Title: _____

Marital Status: Single Married Divorced Separated Widowed

Number of hours worked per week: _____

Date of Full Time Hire (MM DD YYYY): _____

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

Child Name MI Sex Student Birth Date (MM DD YYYY) Social Security Number Pre-Paid Office # (See directory)

Child Name MI Sex Student Birth Date (MM DD YYYY) Social Security Number Pre-Paid Office # (See directory)

Child Name MI Sex Student Birth Date (MM DD YYYY) Social Security Number Pre-Paid Office # (See directory)

Child Name MI Sex Student Birth Date (MM DD YYYY) Social Security Number Pre-Paid Office # (See directory)

Child Name MI Sex Student Birth Date (MM DD YYYY) Social Security Number Pre-Paid Office # (See directory)

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) _____

