



**Midwest Regional Office**  
**P. O. Box 8012**  
**Appleton, WI 54912-8012**

**CITY OF NEWTON**  
**DENTAL INSURANCE ENROLLMENT FORM**

PLEASE PRINT OR TYPE~SEE INSTRUCTIONS ON BACK

**Retiree Plan – Guardian Dental**

1. PLAN HOLDER NAME: <b>CITY OF NEWTON</b>		2. EFFECTIVE DATE:		3. GROUP #: <b>438079</b>		4. Division #:		5. Employee #:	
6. LAST NAME:			7. FIRST NAME:			8. SOCIAL SECURITY #:		9. DOB:	10. SEX:
11. HOME ADDRESS:			12. CITY:		13. STATE:	14. ZIP:	15. PHONE #: (    )		
16. I AM A RETIREE OF: <input type="checkbox"/> Newton Retirement System (City) <input type="checkbox"/> MTRB Retirement (School Department)								<u>Deduction Code</u> <i>HR Use Only</i>	
<input type="checkbox"/> <b>I ELECT GUARDIAN DENTAL COVERAGE</b>									
17. PLEASE LIST ALL ELIGIBLE DEPENDENT (S) COVERED UNDER YOUR POLICY:									
First Name		Last Name			Date of Birth	Sex	Relationship		Full-Time Student?
18. REASON FOR SUBMISSION (Check Applicable Boxes)									
<input type="checkbox"/> Qualifying Event (Description): _____ Date: _____ <input type="checkbox"/> New Addition: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Change: <input type="checkbox"/> Individual to Family <input type="checkbox"/> Family to Individual <input type="checkbox"/> Termination: Date of Termination: _____ <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement <input type="checkbox"/> COBRA Reinstatement of Subscribe <input type="checkbox"/> Name/Address Change <input type="checkbox"/> COBRA New addition of dependent formerly covered under I.D.#: _____ <input type="checkbox"/> Remove Dependent from Student Status									
19. COORDINATION OF BENEFITS									
Are you <b>OR</b> any other family member covered by another dental plan? <input type="checkbox"/> YES <input type="checkbox"/> NO									
If <b>YES</b> , please indicate name of subscriber: _____									
OTHER DENTAL INSURANCE COMPANY:			EMPLOYER NAME:			POLICY HOLDER I.D. #:		EFFECTIVE DATE:	
I authorize my employer to take deductions from my pay if contributions are required for the insurance. The information provided is true and correct to the best of my knowledge. Any person who with the intent to defraud or knowing that he/she 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.									
_____ Signature of Employee					_____ Date				

## **Instructions for completing the Guardian Dental Insurance Enrollment Form**

**If you wish to enroll, make changes or terminate your dental insurance:**

1. Please complete the Enrollment Form on the reverse side.
2. Include all dependent information, if appropriate.
3. Examples of some Qualifying Events:
  - New Enrollment
  - Birth or Adoption of child
  - Death
  - Marriage/Divorce/Legal Separation
  - Loss of Insurance Coverage
  - Reduction in Hours
4. Sign and date the Enrollment Form.
5. Mail Form to:  
Human Resources, Room 218  
City of Newton 1000 Commonwealth Avenue  
Newton Center MA 02459

**Or**

Fax Form to (617) 796-1272