GUARDIAN

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

Active Employee – Guardian Dental

1. PLAN HOLDER NAME: **CITY OF NEWTON**	2. EFFECTIVE DATE:	3. GROUP #: **438073**	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. ☐ Municipal. Employee **I GET PAID** (check appropriate box)

☐ Weekly - 52 paychecks ☐ Monthly - 12 paychecks

Deduction Code
HR Use Only

17. ☐ **I ELECT BASIC DENTAL** ☐ **I ELECT HIGH OPTION DENTAL**

18. PLEASE LIST ALL ELIGIBLE DEPENDENT (S) COVERED UNDER YOUR POLICY:
* Full time Student is a child over the age of 20 who has not reached age 26 and is attending a full time two or four year School.

First Name	**Last Name**	**Date of Birth**	**Sex**	**Relationship**	*** Full-Time Student**

19. REASON FOR SUBMISSION (Check Applicable Boxes)

☐ Qualifying Event (Description): _____ Date: _____

☐ New Addition: ☐ Individual ☐ Family,

☐ Change: ☐ Basic to High Option ☐ High Option to Basic **and/or** ☐ Individual to Family ☐ Family to Individual

☐ Termination: Date of Termination: _____

☐ Add Dependent to Family

☐ Reinstatement ☐ COBRA Reinstatement of Subscribe

☐ Name/Address Change ☐ COBRA New addition of dependent formerly covered under I.D.#: _____

☐ Remove Dependent from Student Status

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

<u>If you wish to enroll, make changes or terminate your dental insurance</u>:

1. Please complete the Enrollment Form on the reverse side.

2. Include all dependent information, if appropriate.

3. Be sure to check the box to elect either Basic or High Option Coverage.

4. Examples of some Qualifying Events:
   - New Enrollment
   - Birth or Adoption of child
   - Death
   - Marriage/Divorce/Legal Separation
   - Loss of Insurance Coverage
   - Reduction in Hours

5. Sign and date the Enrollment Form.

6 Mail Form to:
Human Resources, Room 210
City of Newton 1000 Commonwealth Avenue
Newton Center MA 02459

Or

Fax Form to (617) 796-1272