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

Retiree Plan – Guardian Dental

1. PLAN HOLDER NAME: **CITY OF NEWTON**	2. EFFECTIVE DATE:	3. GROUP #: **438079**	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: ☐ Newton Retirement System (City) ☐ MTRB Retirement (School Department) | Deduction Code *HR Use Only*

☐ **I ELECT GUARDIAN DENTAL COVERAGE**

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)

☐ Qualifying Event (Description): _____ Date: _____

☐ New Addition: ☐ Individual ☐ Family

☐ Change: ☐ 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

19. COORDINATION OF BENEFITS

Are you ***OR*** any other family member covered by another dental plan? ☐ YES ☐ NO

If ***YES***, 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