(Please type or print in ink. This form may be photocopied or duplicated)

Please choose one:

Add ____
Change ____
Waiver ____
COBRA ____

Group Dental & Vision Employee Enrollment Form

Underwritten by: National Guardian Life Insurance Company
Administered by: Cypress Dental Administrators, 7510 Shoreline Drive, Suite A-1, Stockton, CA 95219, (800) 350-3989

Effective Date____

Company____________________________________ City______________________________ State___ Zip Code_________

TO BE COMPLETED BY EMPLOYEE (Please Print)

Name____
Last First Middle Initial

Last four digits of Social Security Number ___ ___ ___ ___ Sex____________________________________

Address____

City____ State______________ Zip Code_________________

Birth Date____ Age_______________ Marital Status__________________________________

Home Phone____ Work Phone____

Permanent Full-time Date Employed________________________________ Hours Worked Per Week_________________________________

EMPLOYEE ELECTION(S)

	Yes	No
Dental	☐	☐
Vision	☐	☐

DEPENDENT ELECTION(S)

	Spouse	Child(ren)	Spouse & Child(ren)	None
Dental	☐	☐	☐	☐
Vision	☐	☐	☐	☐

NAME OF DEPENDENT(S)	RELATIONSHIP (SPOUSE/PARTNER/SON/DAUGHTER)	Male	Female	DATE OF BIRTH
______________________	______________	☐	☐	______________
______________________	______________	☐	☐	______________
______________________	______________	☐	☐	______________
______________________	______________	☐	☐	______________

Application must be made within 31 days from the date the employee becomes eligible (or as otherwise stated in the policy). If plan in contributory, this form **MUST** be signed and dated to authorize payroll deductions. **Should you decline coverage(s), you MUST complete the bottom of this form.** I represent that my answers and statements are correct to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Do you or any of your dependents have other dental insurance? ☐ Yes ☐ No
If yes, please give: Policyholder____ and Insurance Company______________________________________.

Signature of Employee____ **Date**_________/_________/_________

WAIVER OF GROUP INSURANCE

Employee Name_____________________________________ Social Security Number_________ - ______ - _________

Group Policy No.(s)__________________________ __________________________ ______________________

Policyholder Name__________________________________ Date Employment Began___________________________

I have been given an opportunity to apply for Group Insurance as offered by the Policyholder and, after careful consideration, have decided **not** to enroll in the following coverages:

☐ Dental ☐ Vision

For:
☐ Myself (and all eligible dependents if applicable)
☐ My eligible dependent spouse and children only
☐ My eligible dependent spouse only
☐ My eligible dependent children only

Reason:
☐ Cannot afford
☐ Covered under another employer health plan benefit
☐ Covered under an alternate health plan provided by my employer
☐ Other Insurance/Reason____________________

Should I apply for a waived coverage in the future, I understand that my dependent(s) and I will be **considered a late enrollee(s)** and evidence of insurability, at my expense, acceptable to the Insurance Company will be required. I also understand that my first year Dental or Vision benefits may be limited.

The above provisions will apply unless otherwise stated in my policy, or unless prohibited by any applicable state or federal law.

____ ________/_______/________
Signature of Employee Date