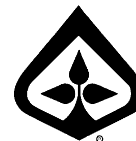
Enrollment/Change Form

DENTAL INSURANCE & VISION INSURANCE

Underwritten by National Guardian Life Insurance Company

Administered by: Beam Insurance
Administrators PO Box 75372
Cincinnati, OH 45275

Please print and complete all sections.



GROUP/EMPLOYEE/MEMBER INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)

Group/Policyholder Name	Group Number	Location	Effective Date	Date of Hire

☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City/State/Zip	Home Phone ( )	Work Phone ( )

Email Address	Cell Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name or coverage)
Note: Children and Stepchildren of your Spouse or Domestic Partner are also eligible.

	Sex	Last Name	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student or handicapped? ☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No

NOTE for Dental: Members that waive coverage at initial enrollment (within thirty-one (31) days of effective date) or in the new eligibility period and/or terminate coverage will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying.
NOTE for Vision: Members that waive coverage at initial enrollment (within thirty-one (31) days of effective date) or in the new eligibility period and/or terminate coverage are restricted to vision exams for twelve (12) months.

Employee/Member Signature: ______________________ Date: ______________

I elect the following coverage(s):

☐Dental		☐Vision	
☐Employee Only	$ ____	☐Employee Only	$ ____
☐Employee + Spouse	$ ____	☐Employee + Spouse	$ ____
☐Employee + Child(ren)	$ ____	☐Employee + Child(ren)	$ ____
☐Employee Family	$ ____	☐Employee Family	$ ____
☐Waived due to other coverage		☐Waived due to other coverage	
☐Waive		☐Waive	

Do you or any of your dependents have other dental or vision insurance? ☐ **Yes** ☐ **No**

If yes, please give: Policyholder________________ and Insurance Company ____________________.

Declination of coverage must be accompanied by the Employee's/Member's signature above.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.