

Underwritten by: National
Guardian Life Insurance
Company
Administered by: Dentist
Direct, LLC
75 S. 500 W.
Bountiful, UT 84010
1-866-696-6527; in Salt Lake
City, call 292-0100

Dentist Direct Employee Benefits Dental & Vision INSURANCE



Offered by: Teamworks

Enrollment/Change Form

Please print and complete all sections. See instructions
below.

EMPLOYER/EMPLOYEE INFORMATION						
Employer Name		Group Number	Location	Effective Date	Date of Hire	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Employee or subscriber)	First Name		M.I.	Date of Birth	Social Security Number
Home Street Address			City/State/Zip		Home Phone ()	
					Work Phone ()	

FAMILY INFORMATION (Only those eligible may be enrolled.)					
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name		M.I.	Date of Birth
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name		M.I.	Date of Birth
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name		M.I.	Date of Birth
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name		M.I.	Date of Birth
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name		M.I.	Date of Birth
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name		M.I.	Date of Birth

NOTE: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under **Coverage A** in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. This limited coverage also applies to the Late Entrant's or Re-enrollee's Dependents, if enrolled.

Do you or any of your dependents have other [dental or vision] insurance? Yes No

If yes, please give: Policyholder _____ and Insurance Company _____.

Employee Signature: _____ **Date:** _____

I elect the following coverage(s):

- | | |
|--|--|
| <input type="checkbox"/> <u>Dental</u>

<input type="checkbox"/> EE <input type="checkbox"/> <u>Plan Option</u>
<input type="checkbox"/> ES <input type="checkbox"/> Option 1
<input type="checkbox"/> EC <input type="checkbox"/> Option 2
<input type="checkbox"/> EF <input type="checkbox"/> Option 3
<input type="checkbox"/> <input type="checkbox"/> Option 4 (discount plan)
<input type="checkbox"/> Waived | <input type="checkbox"/> <u>Vision</u>

<input type="checkbox"/> EE <input type="checkbox"/> <u>Plan Option</u>
<input type="checkbox"/> ES <input type="checkbox"/> Option 1
<input type="checkbox"/> EC <input type="checkbox"/> Option 2
<input type="checkbox"/> EF <input type="checkbox"/> Option 3
<input type="checkbox"/> Waived |
|--|--|

Declination of coverage must be accompanied by the employee's signature above.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.