Enrollment/Change Form

DENTAL INSURANCE

Underwritten by National Guardian Life Insurance Company

Administered by: Beam Administrators LLC

266 N. 4th St. 2nd Fl. Columbus, OH 43215

EMPLOYEE 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.

☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (Spouse or Domestic Partner)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	Sex ☐ 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	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐ Yes ☐ No
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐ Yes ☐ No
☐ A ☐ T ☐ C	Sex ☐ 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 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.

Employee Signature:_____ Date: _____

I elect the following coverage(s):

☐ Dental

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

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

If yes, please give: Policyholder_____ and Insurance Company_____.

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

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