GUARDIAN Dental and (optional) Vision Insurance Enrollment

Return form to Lake County Board of DD/Deepwood Human Resources Department

Group Name: Lake County Board of DD/Deepwood **Guardian Group Number 445757**

Employee is to complete sections A, B, and C, and provide documentation listed on reverse.

A. EMPLOYEE INFORMATION

FIRST NAME	M. I.	LAST NAME		
STREET ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE NUMBER, WITH AREA CODE		DATE INSURANCE IS EFFECTIVE		
DATE OF BIRTH (MM/DD/YY)	SOCIAL SECURITY NUMBER	DATE OF EMPLOYMENT		
OCCUPATION	HOURS WORKED PER WEEK	GENDER: M F		

B. DEPENDENT INFORMATION--Must provide ALL documentation listed on reverse side

MARRIAGE DATE (MM/DD/YY): Attach copy of marriage certificate

SPOUSE NAME (last, first, m.i.)	SPOUSE SS#	SPOUSE BIRTHDATE (MM/DD/YY)	GENDER

Child(ren) (if applicable) (ATTACH COPY OF BIRTH OR ADOPTION CERTIFICATE FOR EACH CHILD)

CHILD NAME (LAST, FIRST, M.I.)	CHILD SS#	BIRTHDATE (MM/DD/YY)	GENDER	FULLTIME STUDENT? Y N
CHILD NAME (LAST, FIRST, M.I.)	CHILD SS#	BIRTHDATE (MM/DD/YY)	GENDER	FULLTIME STUDENT? Y N
CHILD NAME (LAST, FIRST, M.I.)	CHILD SS#	BIRTHDATE (MM/DD/YY)	GENDER	FULLTIME STUDENT? Y N
CHILD NAME (LAST, FIRST, M.I.)	CHILD SS#	BIRTHDATE (MM/DD/YY)	GENDER	FULLTIME STUDENT? Y N

ATTACH COPY OF FULL TIME SCHOOL SCHEDULE FOR EACH CHILD AGE 19 OR OLDER

PLEASE INDICATE YOUR CHOICE OF PLAN BELOW: (must also sign & return the attached Acknowledgment)

X_____ I elect Dental HMO (7-digit provider no.: __ __ __ __ __ __ __) --OR--

X_____ I elect Dental PPO Plan

Optional Vision Plan (please CIRCLE plan choice if electing): Employee-only $5.75/pay Plus Spouse $9.18/pay Plus Child(ren) $9.35/pay Full Family $15.10/pay

C. OTHER DENTAL INSURANCE COVERAGE THAT WOULD BE *PRIMARY* COVERAGE:

If you or your spouse or children have other dental insurance under a group plan, please provide the following:

Name(s) of person(s) covered Effective date of other coverage Name of other dental insurance

If you waive dental coverage and later decide to enroll, you may be subject to late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late entrant penalties if you lose coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

I attest that the information provided above is true and accurate to the best of my knowledge. I agree that my employer may deduct premiums from my pay or add premiums to my dues, if they are required for the coverages I have chosen.

D. AUTHORIZATION

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

INSURED'S SIGNATURE **X**	DATE

On Reverse Side: LCMRDD Group Insurance Dependent Documentation Requirements (Documentation must be attached for EACH dependent to be covered)