Enrollment/Change Form

DENTAL & VISION INSURANCE

Underwritten by National Guardian Life Insurance Company
Administered by: Argus Dental & Vision
4010 W. State St Tampa FL 33609
(855)819-1873

Please print and complete all sections.

GROUP/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	Last Name (Member)	First Name	M.I.	Date of Birth	Social Security Number
☐ A ☐ T ☐ C	☐ M ☐ F					

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)

A/T/C	Sex	Last Name	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	☐ M ☐ F	(spouse)				
☐ A ☐ T ☐ C	☐ M ☐ F	(dependent)				Child unmarried and full-time student or handicapped? ☐ Yes ☐ No
☐ A ☐ T ☐ C	☐ M ☐ F	(dependent)				☐ Yes ☐ No
☐ A ☐ T ☐ C	☐ M ☐ F	(dependent)				☐ Yes ☐ No
☐ A ☐ T ☐ C	☐ M ☐ F	(dependent)				☐ Yes ☐ No
☐ A ☐ T ☐ C	☐ M ☐ F	(dependent)				☐ 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.
NOTE for Vision: Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage are restricted to vision exams for 12 months.

Member Signature: _____ Date: _____

I elect the following coverage(s):

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

☐ Vision
- ☐ 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 or vision] insurance? ☐ Yes ☐ No

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

Declination of coverage must be accompanied by the Member'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.