Enrollment/Change Form

DENTAL & VISION INSURANCE

Underwritten by National Guardian Life Insurance Company

Administered by: Cypress Ancillary Benefits
7510 Shoreline Drive, Ste A1, Stockton, CA 95219
Toll Free: (800)350-3989 Fax: (209)478-5614 Email: billing@cypressadmin.com

Please print and complete all sections.

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

Group Name:	Company Division:	Group Number:	Effective Date:	Plan: ☐ DHMO Dentist Office (Req. for DHMO): ☐ PPO	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 (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

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

☐ 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 Employee'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.