Midwest Regional Office
P. O. Box 8012
Appleton, WI 54912-8012

CITY OF NEWTON
DENTAL INSURANCE ENROLLMENT FORM

PLEASE PRINT OR TYPE~SEE INSTRUCTIONS ON BACK

Active Employee – Guardian Dental

1. PLAN HOLDER NAME: **CITY OF NEWTON**	2. EFFECTIVE DATE:	3. GROUP #: **438073**	4. Division #:	5. Employee #:

6. LAST NAME:	7. FIRST NAME:	8. SOCIAL SECURITY #:	9. DOB:	10. SEX:

11. HOME ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. PHONE #: ( )

16. ☐ School Dept. Employee **I GET PAID** (check appropriate box)

☐ Weekly - 52 paychecks (Custodian's & Food Service Staff) ☐ Semi-Monthly - 24 paychecks (Teachers, Administrators, Non-Aligned, etc.)

☐ Weekly - 40 paychecks (Food Service Staff) ☐ Semi-Monthly – 20 paychecks (Aides)

Deduction Code
HR Use Only

17. ☐ **I ELECT BASIC DENTAL** ☐ **I ELECT HIGH OPTION DENTAL**

18. PLEASE LIST ALL ELIGIBLE DEPENDENT (S) COVERED UNDER YOUR POLICY:
* Full time Student is a child over the age of 20 who has not reached age 26 and is attending a full time two or four year School.

First Name	**Last Name**	**Date of Birth**	**Sex**	**Relationship**	* **Full-Time Student**

19. REASON FOR SUBMISSION (Check Applicable Boxes)

☐ Qualifying Event (Description): ______________________ Date: ______________

☐ New Addition: ☐ Individual ☐ Family

☐ Change: ☐ Basic to High Option ☐ High Option to Basic **and/or** ☐ Individual to Family ☐ Family to Individual

☐ Termination: Date of Termination: ______________

☐ Add Dependent to Family

☐ Reinstatement ☐ COBRA Reinstatement of Subscribe

☐ Name/Address Change ☐ COBRA New addition of dependent formerly covered under I.D.#: ________

☐ Remove Dependent from Student Status

I authorize my employer to take deductions from my pay if contributions are required for the insurance. The information provided is true and correct to the best of my knowledge. Any person who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer; submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

______________________ ______________________
Signature of Employee Date

Instructions for completing the
Guardian Dental Insurance Enrollment Form

If you wish to enroll, make changes or terminate your dental insurance:

1. Please complete the Enrollment Form on the reverse side.

2. Be sure to check the box to elect either Basic or High Option Coverage.

3. Include all dependent information, if appropriate.

4. Examples of some Qualifying Events:

   - Open Enrollment
   - New Enrollment
   - Birth or Adoption of child
   - Death
   - Loss of Insurance Coverage
   - Marriage/Divorce/Legal Separation
   - Reduction in Hours

5. Sign and date the Enrollment Form.

6. Mail Form to:
   Newton Public Schools, 100 Walnut Street, Newtonville, MA 02460
   Attn: Human Resources, Room 201 or Fax Form to (617) 559-6010