GUARDIAN

AAQHC, *An Administrator*
23251 Mulholland Drive, Woodland Hills, CA 91364
(818) 591-8700 • Fax (818) 591-8722 • info@aaqhc.com

Individual and Family Dental Enrollment Form

Insured by:
Guardian Life Insurance Company of America

NOTE: PLEASE COMPLETE ALL INFORMATION

☐ **NEW ENROLLMENT**	☐ **CHANGE**	**EFFECTIVE DATE** (MM/DD/CCYY)

TYPE OF CHANGE:

☐ **Add Dependent(s)*** Date: ______________ ☐ **Address Change** ☐ **Other** ______________

☐ **Cancel Dependent(s)*** Last Date of Coverage: ______________

***List Names Below**

NAME *(Last)*	*(First)*	*(M.I.)*	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH** (MM/DD/CCYY)

ADDRESS	*Apt. #*	*City*	*State*	*Zip Code*

TELEPHONE **HOME:** ( ) **WORK:** ( )	**E-MAIL ADDRESS**

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* Last Name / First Name / M.I.	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH** (MM/DD/CCYY)	**GENDER**	*If you choose a Guardian Dental HMO Option: Enter your choice of* ***Dental Office Number*** *below*	**EXISTING PATIENT** Yes No	*(Check one)*
Applicant			☐ M ☐ F	PCD ID#	☐ ☐	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	PCD ID#	☐ ☐	☐ Add ☐ Cancel
Dependent* Relationship			☐ M ☐ F	PCD ID#	☐ ☐	☐ Add ☐ Cancel
Dependent* Relationship			☐ M ☐ F	PCD ID#	☐ ☐	☐ Add ☐ Cancel
Dependent* Relationship			☐ M ☐ F	PCD ID#	☐ ☐	☐ Add ☐ Cancel

DENTAL PLAN OPTION:

☐ LOW-OPTION DHMO ☐ MID-OPTION DHMO ☐ HIGH-OPTION DHMO ☐ DPPO ☐ VOLUNTARY TERM LIFE* $______________

***If you choose Guardian Term Life Insurance above, please complete the beneficiary form.**

I hereby apply for the benefit(s) that I have chosen above.
I have reviewed the statements made by me on this application, and they are true and complete to the best of my knowledge and belief.
I attest that the information provided above is true and correct to the best of my knowledge.
Any person, who with 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.
By my signature below, I acknowledge that AAQHC, An Administrator, endorses the Guardian plan of insurance.

APPLICANT'S SIGNATURE	**DATE**	**SPOUSE'S SIGNATURE**	**DATE**

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