

GUARDIAN

Individual and Family Dental Enrollment Form

AAQHC, An Administrator

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

Insured by:
 Guardian Life Insurance Company of America

NOTE: PLEASE COMPLETE ALL INFORMATION

<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> CHANGE	EFFECTIVE DATE (MM/DD/CCYY)
TYPE OF CHANGE:		
<input type="checkbox"/> Add Dependent(s)* Date: _____	<input type="checkbox"/> Address Change	<input type="checkbox"/> Other _____
<input type="checkbox"/> 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			E-MAIL ADDRESS	
HOME: ()		WORK: ()		

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

DENTAL PLAN OPTION:

LOW-OPTION DHMO
 MID-OPTION DHMO
 HIGH-OPTION DHMO
 DPPO
 VOLUNTARY TERM LIFE \$ _____
 VOLUNTARY SPOUSE TERM LIFE
 VOLUNTARY DEPENDENT 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