Please print clearly to ensure accurate processing

GUARDIAN®

Employer:
HPS Mechanical, Inc.
3100 E Belle Ter
Bakersfield, CA 93307

Guardian Group Plan Number: **486848**

The Guardian Life Insurance Company of America

Managed Dental Care of California
A wholly owned subsidiary of Guardian

EMPLOYER USE ONLY ☑ New Application ☐ Add Dependent(s) ☐ Drop Dependent(s) ☐ Change Address ☐ Change Name ☐ Drop Coverage as of: / /

Class	Hours Worked	Division	Benefits Effective
All Eligible Employees			5 /1 /14

Keep a copy for your records and return form to: **Western Regional Office, P.O. Box 2454, Spokane, WA 99210-2454**

ABOUT YOURSELF

Print clearly in black or blue ink.

First, Middle Initial, Last Name ☑ Add ☐ Change ☐ Drop	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	Social Security Number
		/ /	

Address	City	State	Zip

Preferred E-mail	Day Phone	Eve Phone	The best way to reach you: ☐ E-mail ☐ Day Phone ☐ Eve Phone

Job Title	Work Status ☐ Full-Time ☐ Part-Time ☐ Retired ☐ COBRA/State Continuation	Date work status began / /

Are you married? ☐ Yes ☐ No If you have a domestic partner (DP), is your partnership registered with the State of California? ☐ Yes ☐ No

Do you have children or other dependents? ☑ Yes ☐ No

ABOUT YOUR DEPENDENTS

☐ A sheet with information about additional dependents is attached.

	Sex	Date of Birth (mm/dd/yyyy)	Social Security Number		
Spouse/DP First, Middle Initial, Last Name ☐ Add ☐ Change ☐ Drop	☐ M ☐ F	/ /		Marriage Date (mm/dd/yyyy)	
Child 1 ☐ Add ☐ Change ☐ Drop	☐ M ☐ F	/ /		☐ Full-time student, at (school):	Attending Since / /
Child 2 ☐ Add ☐ Change ☐ Drop **Se**	☐ M ☐ F	/ /		☐ Full-time student, at (school):	Attending Since / /
Child 3 ☐ Add ☐ Change ☐ Drop	☐ M ☐ F	/ /		☐ Full-time student, at (school):	Attending Since / /
Child 4 ☐ Add ☐ Change ☐ Drop	☐ M ☐ F	/ /		☐ Full-time student, at (school):	Attending Since / /

To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages.
☐ Dental

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Mar 28, 2013

CHOOSE YOUR DENTAL COVERAGE

Check one box only

	Option 1: Pre-Paid	Option 2: PPO		
Employee alone	❑	❑		❑ I waive this coverage
Employee and Spouse/DP	❑	❑		❑ I waive this coverage
Employee and Child(ren)	❑	❑		❑ I waive this coverage
Entire family	❑	❑		❑ I waive this coverage

List dental office location number(s) (Pre-Paid Plan only)

Employee _____ Spouse/DP _____ Child(ren) _____

❑ A separate sheet with additional dental office numbers for dependents is attached.

If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.

Reason for Loss of coverage: ❑ Termination of Employment ❑ Divorce ❑ Death of Spouse/DP ❑ Termination or Expiration of coverage	Date of coverage loss / /
If you are waiving coverage, are you covered under another dental plan? ❑ Yes ❑ No	If you are waiving dependent coverage, are your dependents covered under another dental plan? ❑ Yes ❑ No

IMPORTANT NOTES

- Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse/DP, divorce or where a court has ordered coverage be provided for an eligible spouse/DP or eligible children, provided you apply within 30 days.

- Late entrant penalties or proof of insurability do not apply to Pre-Paid dental coverage. The Pre-Paid dental plan refers to, as applicable, Managed DentalGuard dental HMO plans underwritten by Managed Dental Care. Eligibility for this coverage is only available at the open enrollment period.

SIGNATURE

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- **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.**

SIGNATURE OF EMPLOYEE X _____ **DATE** _____