

## 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

CROUPFEMPLOYEE INFORMATION         A: Add (enrol)         T: Terminate         C: Change (change of name or coverage)           Group Name         Group Number         Location         Effective Date         Date of Hire           A         Sex         Last Name         First Name         M.I.         Date of Birth         Social Security Number           B         C         F	Please print and complete <u>all</u> sections.								
A       Sex       Last Name       First Name       M.L.       Date of Birth       Social Security Number         Bone Street Address       City/State/Zip       Home Phone       ( )       ( )         Email Address       City/State/Zip       Home 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.       M.I.       Date of Birth       C: Change (change of name or coverage)         A       Sex       Last Name (Spouse or Domestic Partner are also eligible.       MI.       Date of Birth       Child unmarried and full-time student or handicapped?         C       F       Partner)       First Name       M.I.       Date of Birth       Child unmarried and full-time student or handicapped?         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         C       F       Sex									
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C       F       Home Street Address       City/State/Zip       Home Phone       Work Phone         Home Street Address       City/State/Zip       Home Phone       ()       ()         Email Address       City/State/Zip       Home 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       First Name       M.I.       Date of Birth			First Name		M.I.	Date of Birth	Socia	al Security Nu	mber
Email Address       Cell Phone         FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate Note: Children and Stepchildren of your Spouse or Domestic Partner are also eligible.       C: Change (change of name or coverage)         A       Sex       Last Name (Spouse or Domestic Partner are also eligible.       M.I.       Date of Birth         C       F       Partner)       First Name       M.I.       Date of Birth       Child unmarried and full-time student or handicapped?         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Child unmarried and full-time student or handicapped?         C       F       M       Extended to the partner       First Name       M.I.       Date of Birth       Child unmarried and full-time student or handicapped?         C       F       M       Extended to the partner       First Name       M.I.       Date of Birth       Child unmarried and full-time student or handicapped?         C       F       M       Extended to the partner       First Name       M.I.       Date of Birth       Yes       No         C       F       F       First Name       M.I.       Date of Birth       Yes       No         C       F       Last Name (dependent)       First Name       M.I.       Date of Birth									
Image: I	Home Street Address	Home Street Address City/State/Zip		Hon		e Phone		Work Phone	
Image: I			(		) (		)		
Note: Children and Stepchildren of your Spouse or Domestic Partner are also eligible.       M.I.       Date of Birth         T       M       Partner       First Name       M.I.       Date of Birth         C       F       Partner       First Name       M.I.       Date of Birth       Child unmarried and full-time student or handicapped?         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Child unmarried and full-time student or handicapped?         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Child unmarried and full-time student or handicapped?         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         C       F        First Name       M.I.       Date of Birth       Yes       No         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         C       F        First Name       M.I.       Date of Birth       Yes       No         C       F	Email Address Cell Phone								
A       Sex       Last Name (Spouse or Domestic Partner)       First Name       M.I.       Date of Birth         C       F       Partner)       First Name       M.I.       Date of Birth       Child unmarried and full-time student or handicapped? 									
C       F       Image: Constraint of the constraint o	A Sex Last Name (Spouse or Do				M.I.	Date of Birth			
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C       F       Image: Sector of the			First Name		M.I.	Date of Birth		Child unm	arried and
A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         T       M       F       F       F       No       P       No         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         C       F       Image: Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         A       Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         C       F       Image: Sex       Last Name (dependent)       First Name       M.I.       Date of Birth       Yes       No         C       F       Image: Sex       Image: Sex       Image: Sex       Image: Sex       Image: Sex       Image: Sex <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
ASexLast Name (dependent)First NameM.I.Date of BirthYesNoCFImage: SexImage: Sex									
T       M       Yes       No         C       F       F       Image: Second secon	Δ Sex Last Name (dependent)		First Name		M.L	Date of Birth		<u> </u>	
C       F       Image: Constraint of the system of	$\Box$ T $\Box$ M				Date of Birth			□Yes	No
T       M       Yes       No         C       F       F       Image: Second secon									
C       F       Image: Constraint of the second sec		Last Name (dependent)		First Name		M.I. Date of Birth			
A     Sex     Last Name (dependent)     First Name     M.I.     Date of Birth       T     M     C     F     Image: Sex of the sex of								Yes	No
□ T □ M □ C □ F □ □ Ves □No			First Nome		мт	Data of Birth			
				rnst name		MI.I. Date of Birth			□No
Employee Signature: Date:									
Employee Signature:    Date:									
	Employee Signature:			Date:					
	-								

I elect the following coverage(s): SELECT PLAN [] DHMO [] MAC [] UCR					
Dental	Vision				
Employee Only <u>\$</u>	Employee Only <u>\$</u>				
Employee + Spouse <u>\$</u>	$\square Employee + Spouse \qquad \qquad \underline{\$}$				
$\Box Employee + Child(ren) \qquad \qquad$	$Employee + Child(ren) \qquad \qquad$				
Employee Family <u>\$</u>	Employee Family <u>\$</u>				
Waived due to other coverage	Waived due to other coverage				
Waive	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.