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

Please print and complete all sections.

GROUP/EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name or coverage)

Group Name	Group Number	Location	Effective Date	Date of Hire

☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City/State/Zip	Home Phone	Work Phone
		( )	( )

Email Address	Cell 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.

	Sex	Last Name	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (Spouse or Domestic Partner)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Child unmarried and full-time student or handicapped? ☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No
☐ A ☐ T ☐ C	☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	☐Yes ☐No

Employee Signature: ______________________________ Date: ____________________

I elect the following coverage(s): SELECT PLAN [ ] DHMO [ ] MAC [ ] UCR

☐Dental		☐Vision	
☐Employee Only	$_____	☐Employee Only	$_____
☐Employee + Spouse	$_____	☐Employee + Spouse	$_____
☐Employee + Child(ren)	$_____	☐Employee + Child(ren)	$_____
☐Employee Family	$_____	☐Employee Family	$_____
☐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.