Please print clearly to ensure accurate processing

GUARDIAN®

Employer:
WANADA Dental Benefits Trust
5301 Wisconsin Avenue NW
Suite 210
Washington, DC 20015

Guardian Group Plan Number: **00472376**

The Guardian Life Insurance Company of America

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			/ /

Keep a copy for your records and return form to: [redacted] WANADA

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

Do you have children or other dependents? ❑ Yes ❑ No

ABOUT YOUR DEPENDENTS

❑ A sheet with information about additional dependents is attached.

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

Child 1 ❑ Add ❑ Change ❑ Drop State of Residence:	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 2 ❑ Add ❑ Change ❑ Drop State of Residence:	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 3 ❑ Add ❑ Change ❑ Drop State of Residence:	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 4 ❑ Add ❑ Change ❑ Drop State of Residence:	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	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

A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exemption. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Oct 26, 2011

CHOOSE YOUR DENTAL COVERAGE				*Check one box only*
	Option 1: Plan 1	**Option 2: Plan 2**	**Option 3: Plan 3**	
Employee alone	❑	❑	❑	❑ I waive this coverage
Employee and 1 Dependent	❑	❑	❑	❑ I waive this coverage
Entire family	❑	❑	❑	❑ I waive this coverage
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 ❑ 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, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

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 acknowledge and agree that Guardian may provide me information concerning benefits, including explanation of benefit statements and other claims related information soley in electronic format as permitted by law. I may change this election only by providing Guardian thirty (30) day prior written notice.
- **I attest that the information provided above is true and correct to the best of my knowledge.**
- **WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.**

SIGNATURE OF EMPLOYEE X _____ **DATE** _____