ARCHDIOCESE OF NEW ORLEANS

OPEN ENROLLMENT ENROLLMENT FORM

Guardian Group ID #: 538205 (Dental & Vision)

Plan Source Use	TYPE OF ENROLLMENT: ☐ New Hire ☐ Annual Open Enrollment ☐ Late Entrant	Location/Division Code	LOCATION NAME:	DATE OF HIRE:

☐ Is this Enrollment Due to a Qualifying Life Event (Event examples: Marriage, Birth, Adoption, Divorce) Event: _____	DATE OF LIFE EVENT:	EMPLOYEE PHONE # ☐ Cell ☐ Home	EMPLOYEE EMAIL ADDRESS:

EMPLOYEE NAME:	EMPLOYEE DATE OF BIRTH:	EMPLOYEE SOCIAL SECURITY #:	MARITAL STATUS:	DATE OF MARRIAGE: (IF APPLICABLE)	EMPLOYEE GENDER:

ADDRESS:	SS#	CITY:	STATE:	ZIP:
SPOUSE NAME	SS#	SPOUSE DATE OF BIRTH	SPOUSE GENDER	
CHILD NAME	SS#	CHILD DATE OF BIRTH	CHILD GENDER	FULL-TIME STUDENT? (Y OR N)
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DENTAL with Guardian Policy 538205

PPO DENTAL: You may elect coverage for yourself and your dependents.

Your dental plan uses Guardian's DentalGuard Preferred PPO Network.

Find a Provider Near You at www.GuardianAnytime.com and click on 'Find a Provider'.

Low Plan:

$50 Deductible, $1,250 Annual Maximum

Preventive:	Covered at 100%
Basic :	Covered at 80%
Major:	Not Covered
Ortho:	Not Covered

High Plan:

$50 Deductible, $1,250 Annual Maximum

Preventive:	Covered at 100%
Basic :	Covered at 80%
Major:	Covered at 50% after 6 months
Ortho:	Covered at 50% after 12 months

☐ No change to current election

I want to elect Dental coverage:

☐ Low Plan ☐ High Plan

☐ I want to elect Employee Only Dental coverage.

☐ I want to elect Dental coverage for Employee + 1 Dependent

☐ I want to elect Dental coverage for Employee + 2 or More Dependents

☐ I decline Dental coverage for this Plan Year.

VISION with Guardian Policy 538205

VISION: You may elect coverage for yourself and your dependents.

Your vision plan uses the VSP Signature Network.

Find a Provider: www.GuardianAnytime.com (click on 'Find a Provider').

☐ **No change** to current election

☐ I want to elect Employee Only Vision coverage.

☐ I want to elect Employee + Spouse Vision coverage

☐ I want to elect Employee + Child(ren) Vision coverage

☐ I want to elect Employee + Family Vision coverage

☐ I **decline** Vision coverage for this Plan Year.

EMPLOYEE AUTHORIZATION

I verify that this enrollment form reflects my benefit elections under this plan. I have read the enrollment materials provided to me. I authorize my employer to deduct from my wages or salary any required premium contribution on a post-tax basis (Voluntary Life/Disability) as stipulated by this plan and my elections. I understand that my election will be effective through the end of the Plan Year and that I may not change my elections unless I experience a qualified change in status (as noted in the enrollment materials). If I experience a change in status, I must notify Human Resources and request to change my election within 30 days of the event, or I must wait until the next open enrollment period to change my election.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet

I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

Truth & Knowledge Disclaimer: I attest that the information provided above is true and correct to the best of my knowledge.

Fraud Statement: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

Required Signature/Date:

Name: _____ **Date:** _____