Open Enrollment Effective 7/1/2025

Enrollment / Change Form

Backup documents (copies) are REQUIRED for all dependents you enroll. (marriage cert., birth cert.,with parent's full names, domestic partnership forms.)

IBEW Local 18 – GUARDIAN DENTAL

Guardian Group Plan No.: **00456998**

Effective Date 7/1/2025

☐ New Application ☐ Add Dependent(s) ☐ Remove Dependent(s) ☐ Change Address ☐ Change Name ☐ Drop Coverage as of: / /

Employee Last Name, First Name	Date of hire:	Employee Number

Mailing Address	City	State	Zip

Cell Phone #	Business Phone#	Home Phone #	Preferred Email

Work Status/Eligibility: ☐ Full Time ☐ Part Time ☐ Retired ☐ Cobra

CHOOSE YOUR DENTAL COVERAGE: Check one box only Find dental providers online at www.guardiananytime.com

	Option 1 – DHMO	Option 2 – PPO Dental Guard Preferred
Employee Only	☐	☐
Employee & one	☐	☐
Employee & 2 or more	☐	☐

EMPLOYEE AND FAMILY INFORMATION.

DATE OF MARRIAGE ___/___/_____ Domestic Partner ☐ Yes ☐ No

IF YOU HAVE A DOMESTIC PARTNER, IS YOUR PARTNERSHIP REGISTERED WITH THE STATE OF CALIFORNIA? ☐ Yes ☐ No

		Age	Sex	Date of Birth (mm/dd/yyyy)	SS#	Dental Provider Location # - if electing the DHMO
☐ Add ☐ Change ☐ Drop	Employee First, Middle Initial, Last Name		☐ M ☐ F			
☐ Add ☐ Change ☐ Drop	Spouse/DP First, Middle Initial, Last Name		☐ M ☐ F			
☐ Add ☐ Change ☐ Drop	Child (1):		☐ M ☐ F			
☐ Add ☐ Change ☐ Drop	Child (2):		☐ M ☐ F			
☐ Add ☐ Change ☐ Drop	Child (3):		☐ M ☐ F			
☐ Add ☐ Change ☐ Drop	Child (4):		☐ M ☐ F			

If you or your family has lost dental coverage, please explain below. *Late entrant penalties may apply.*

Reason for Loss of coverage: **Date of coverage loss:**

☐ Termination of Employment. ☐ Divorce. ☐ Death of Spouse. ☐ Termination or Expiration of coverage

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/DP or eligible children, provided you apply within 30 days. Late entrant penalties or proof of insurability do not apply to DHMO dental coverage. The DHMO 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 coverage's that I have chosen above.
- I understand that my dependent(s) cannot be enrolled for 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	DATE

WET SIGNATURE REQUIRED

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO

LOCAL 18 BENEFIT SERVICE CENTER, 9500 Topanga Canyon Blvd, Chatsworth, CA 91311