



**Enrollment/Change Form**  
**DENTAL & VISION INSURANCE**  
 Underwritten by National Guardian Life Insurance Company  
 Administered by: TPA Name  
 PO Box 75372  
 Cincinnati, OH 45275

Please print and complete all sections.

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

Group/Policyholder Name <i>Tupelo Public School Dist.</i>		Group Number <i>MS14105</i>	Location	Effective Date	Date of Hire
<input type="checkbox"/> A    Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name	First Name	M.I.	Date of Birth	Social Security Number
Home Street Address		City/State/Zip	Home Phone (    )	Work Phone (    )	
E-mail Address				Cell Phone (    )	

**FAMILY INFORMATION (Only those eligible may be enrolled.)**    **A: Add (Enroll)    T: Terminate    C: Change (Change of name or coverage)**

<input type="checkbox"/> A    Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (Spouse)	First Name	M.I.	Date of Birth	
<input type="checkbox"/> A    Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (Dependent)	First Name	M.I.	Date of Birth	Child handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A    Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (Dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A    Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (Dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A    Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (Dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A    Sex <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> C <input type="checkbox"/> F	Last Name (Dependent)	First Name	M.I.	Date of Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No

**I elect the following coverage(s):**

<input type="checkbox"/> Dental		<input type="checkbox"/> Vision	
<input type="checkbox"/> Employee Only	\$ _____	<input type="checkbox"/> Employee Only	\$ _____
<input type="checkbox"/> Employee + Spouse	\$ _____	<input type="checkbox"/> Employee + Spouse	\$ _____
<input type="checkbox"/> Employee + Child(ren)	\$ _____	<input type="checkbox"/> Employee + Child(ren)	\$ _____
<input type="checkbox"/> Employee Family	\$ _____	<input type="checkbox"/> Employee Family	\$ _____
<input type="checkbox"/> Waived due to other coverage		<input type="checkbox"/> Waived due to other coverage	
<input type="checkbox"/> Waive		<input type="checkbox"/> Waive	

**Do you or any of your dependents have other dental or vision insurance?**     Yes     No

If yes, please give: Policyholder \_\_\_\_\_ and Insurance Company: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION TO OBTAIN INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.