HealthPass - Guardian
Sole Proprietor Managed DentalGuard Application

Mailing Address: HealthPass, 7120 Lake Ellenor Drive, Orlando, Fl 32809; Fax: 888.354.7277

Effective Date:_____/_____/_____

Type of Coverage:

❍ Enrollment ❍ Termination ❍ Change ❍ COBRA

Name:_____
Last First MI

Address:_____
Street Address City State Zip

Phone:(_____)_____ **Enrolling As:** ____Single ____Parent/Child(ren) ____Husband/Wife ____Family

_____/_____/_____
Date of Birth Social Security Number Dental Facility ID

Spouse:_____
Last First MI Sex

_____/_____/_____
Date of Birth Social Security Number Dental Facility ID

Enrolling as Domestic Partner: ❍Yes ❍No

Child:_____
Last First MI Sex

_____/_____/_____
Date of Birth Social Security Number Dental Facility ID

Child:_____
Last First MI Sex

_____/_____/_____
Date of Birth Social Security Number Dental Facility ID

Child:_____
Last First MI Sex

_____/_____/_____
Date of Birth Social Security Number Dental Facility ID

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature:_____ Date (MM/DD/YYYY) _____/_____/_____