Service Station Dealers & Automotive Services of Greater NY

7/1/24 - 6/30/25

Guardian

Guardian Dental Election Form

Full Name ____ Station Name ____ Effective Date ____

Home Address ____ City ____ State ____ Zip ____

Email Address ____ Home Phone Number ____ Fax Number ____

Plan Features	Dental Guard 2000		Managed Dental Care
	In-Network	Out-of-Network	In-Network Only
Deductible / Maximum Accumulation Period	Calendar Year (1/1 - 12/31)		Calendar Year (1/1 - 12/31)
Dependent Age Limit	20/26		20/26
Network	Dental Guard Pref (NY)	N/A	Managed Dental Care- Guardian (NY)
Reimbursement Level	N/A	UCR 70%	Fee Schedule
Office Visit Co-Pay	None		$5
Plan Deductible (Individual / Family)	$50/$150	$75/$225	None
Deductible Waived For	Preventive	Preventive	N/A
Preventive Care (Cleanings, Oral Exams, etc.)	100%	80%	See fee schedule
Basic Procedures (Extractions, fillings, etc.)	80%	80%	See fee schedule
Major Procedures (Crowns, dentures, etc.)	50%	50%	See fee schedule
Child Orthodontia (up to age 19)	Not Covered		See fee schedule
Plan Year Maximum Benefit	$1,000		Unlimited
Orthodontia Lifetime	N/A		None
Election			
Single	❑ $63.21		❑ $25.95
Employee/Spouse	❑ $126.79		❑ $51.87
Employee/Children	❑ $131.58		❑ $68.32
Family	❑ $195.89		❑ $85.82

- Please visit Guardian at https://www.guardiananytime.com/fpapp/FPWeb/search to find in-network providers. **MUST** include your selected Dental Office # on your enrollment form when selecting the Managed Dental Care plan **ONLY**.
- Guardian enrollment form **must** be completed in addition to dental election form for any changes.

*"**By signing below, in order to avoid cancellation, I agree to pay all insurance premiums by the end of the billing month**."*

Signature ____ SSN ____ Date ____

Please return completed form via Secure Fax to:
(914) 962-0108. If you have any questions, please call (866) 573-4768 ext. 2481