WSTA
WESTERN STATES TRUCKING ASSOCIATION

334 N Euclid Ave, Upland, California 91786

Guardian Dental/Vision Election Form

Plan Year 12/1/2026 – 11/30/2027

Guardian Group #00554633

Employee Information

Employee Name: _____ **SSN:** _____

Home Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Email: _____ **Phone:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner

Employer Name: _____ **Date of Hire:** _____

Section 1: Dental Election

Tier	Guardian DHMO	Guardian DPPO Low ($1,500)	Guardian DPPO High ($2,000)
Employee Only	☐ $11.47	☐ $45.83	☐ $58.04
Employee + 1 Dependent	☐ $21.81	☐ $90.91	☐ $115.13
Employee + 2 or More	☐ $30.41	☐ $150.54	☐ $190.65
☐ I would like to waive/decline dental coverage			

Section 2: Vision Election

Tier	Guardian (VSP)
Employee Only	☐ $7.53
Employee + Spouse	☐ $15.12
Employee + Child(ren)	☐ $12.79
Employee + Family	☐ $21.10
☐ Waive/decline vision coverage	

Note: The rates shown are the total monthly rates and do not include employer contribution. Please check with your employer to find out the contribution amount.

Section 3: Dependent Information

Relationship	Dependent Name	Date of Birth	Age	Social Security Number	Gender	Plan Enrolling (check)
Spouse/DP						☐ Dental ☐ Vision
Child						☐ Dental ☐ Vision
Child						☐ Dental ☐ Vision
Child						☐ Dental ☐ Vision
Child						☐ Dental ☐ Vision
Child						☐ Dental ☐ Vision

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Section 4: Primary Care Dentist – DHMO Plan Only (enter "Auto" to be auto-assigned a PCP)

Member	Guardian Dental PCP #	Guardian Dental PCP Name
Employee		
Spouse/DP		
Child		
Child		
Child		
Child		

Enrollment Contact

Beni GLOBAL

Please contact our benefits brokers at Beni Global if you have any questions regarding enrollment.
Vanessa@beniglobal.com | Elena@beniglobal.com | Valeria@beniglobal.com

SBC (Summary of Benefits and Coverage)	Initial Here
I understand the SBCs (Summary of Benefits & Coverage) and all ACA-required notices can be found on the Employee Navigator portal, employeenavigator.com, under "SBC & Notices," or can be requested from Human Resources.	

Open Enrollment / Waiting Period Acknowledgement	Initial Here
Open Enrollment I acknowledge that all provisions of my employer's benefits have been explained to me, and I have been given the opportunity to participate. I also understand any benefit elections made at this time are effective 12/1/2026 and cannot be changed until 12/1/2027, unless I experience a "Qualifying Event" as defined by the insurance carrier. If I waive coverage during this period, I understand that neither I nor any dependents can enroll in any benefits until 12/1/2027, unless I experience a "Qualifying Event" as defined by the insurance carrier. **Waiting Period** I acknowledge that as a new hire I have a waiting period of the first of the month following date of hire, in which I can enroll in or waive any benefits. I understand any benefit elections made at this time are effective when I meet my waiting period and cannot be changed until 12/1/2027, unless I experience a "Qualifying Event" as defined by the insurance carrier. If I waive coverage during this period, I understand that neither I nor any dependents can enroll in any benefits until 12/1/2027, unless I experience a "Qualifying Event" as defined by the insurance carrier.	

Authorization and Certification

I desire to participate in the coverages selected above and hereby authorize my employer to make the necessary deductions from my wages to pay my portion of the premium. I understand that my payroll deduction amount will change if my coverage or cost changes.

By signing below, I attest that I have reviewed the information provided on this application and, to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Signature: _____ **Date:** _____

SUBMITTING YOUR ENROLLMENT FORM

Email the completed form to ALL FOUR recipients listed below:
Dianna@aadrugtesting.com | Vanessa@beniglobal.com | Elena@beniglobal.com | Valeria@beniglobal.com