DentalGuard Preferred Dentist Nomination Form

I would like to nominate my dentist for inclusion in the DentalGuard Preferred Provider Network. I understand that the Guardian retains final authority for approving membership in the provider network. I also understand that the Guardian may use my name when contacting my dentist and inform him/her of my desire for them to join the network.

NOTE: This form does not serve as an enrollment form for dental insurance or to register with the dental office as a patient.

DATE: _____

Patient's Name: _____

Employer: _____

Phone: _____

DENTIST

Name: _____

Address: _____

_____

_____

Phone: _____

Specialty: _____

Please submit completed form to:

Guardian
DentalGuard Preferred
P.O. Box 2465
Spokane, WA 99210-9817

or FAX to: 509-468-6550

GUARDIAN℠