



**Group Insurance
Enrollment/Change Form**

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

7 Hanover Square, New York, NY 10004

Please print clearly and mark carefully.

Employer Name: _____	Group Plan Number: _____ Benefits Effective: _____
----------------------	---

PLEASE CHECK APPROPRIATE BOX
 Initial Enrollment Add Employee/ Dependents Drop/Refuse Coverage Information Change

Class: _____ Division: _____ Subtotal Code: _____
 (Please obtain this from your Employer)

About You: First, MI, Last Name: _____	Social Security Number ____ - ____ - ____
Address/City/State/Zip: _____	
Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: () -
Email Address: _____	
Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage/union: ____ - ____ - ____
Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placement date of adopted child: ____ - ____ - ____

About Your Job: Hours worked per week: _____ Job Title: _____

Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra/State Continuation	Date of full time hire: ____ - ____ - ____	Annual Salary: \$ _____
--	---	----------------------------

About Your Family: Please include the names of the dependents you wish to enroll for coverage. *A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.*

Spouse (First, MI, Last Name)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____
Child/Dependent 3:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____
Child/Dependent 4:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____

Dental Coverage: You must be enrolled to cover your dependents. Check only one box.

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Option 2 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Option 3 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I do not want this coverage. If you do not want Dental Coverage, please mark all that apply:

I am covered under another Dental plan.

My spouse is covered under another Dental plan.

My dependents are covered under another Dental plan.

Vision Coverage: You must be enrolled to cover your dependents. Check only one box.

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
VSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Davis Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I do not want this coverage. If you do not want Vision Coverage, please mark all that apply:

I am covered under another Vision plan.

My spouse is covered under another Vision plan.

My dependents are covered under another Vision plan.

Dental Tied To Vision Coverage: You must be enrolled to cover your dependents. Check only one box.

When electing Dental coverage for yourself and/or your dependents you also receive Vision Coverage.

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Option 2 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Option 3 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I do not want this coverage. If you do not want this Coverage, please mark all that apply:

<input type="checkbox"/> I am covered under another	Dental plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> My spouse is covered under another	Dental plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> My dependents are covered under another	Dental plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Basic Life Coverage With Accidental Death and Dismemberment (AD&D): Check only one box.

Benefit reductions apply. Please see plan administrator.

<p>Policy Amount</p> <p>Employee Only</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> I do not want this coverage.</p>	<p>NAME YOUR BENEFICIARIES (primary beneficiary percentages must total 100%)</p> <p>Primary Beneficiaries:</p> <p>Name _____ % _____</p> <p>Relationship to employee: _____</p> <p>Name _____ % _____</p> <p>Relationship to employee: _____</p> <p>Contingent Beneficiary: _____</p> <p>(In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)</p>
---	--

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy. \$ _____

IMPORTANT NOTES:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Basic Life.

Voluntary Term Life Coverage: *You must be enrolled to cover your dependents. Check only one box. Benefit reductions apply. Please see plan administrator.*

Policy Amount Check one box only.

I do not want this coverage.

Add Voluntary Life for Spouse

50% of employee's amount to maximum \$ _____

** The amount may not be more than 50% of the employee amount for Voluntary Life.*

I do not want this coverage.

Add Voluntary Life for Dependent/Child(ren)

10% of employee's amount to maximum \$10,000

** The amount may not be more than 10% of the employee amount for Voluntary Life.*

I do not want this coverage.

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.

Name your beneficiaries: (primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life, please name below.

Primary Beneficiaries:

Name: _____ % _____

Relationship to employee: _____

Name: _____ % _____

Relationship to employee: _____

Contingent Beneficiary: _____

(In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Short -Term Disability (STD) Coverage:

Core Weekly Benefit

___% of salary to a maximum of \$ _____

I do not want this coverage.

Buy-Up Option 1

Weekly Benefit

___% of salary to a maximum of \$ _____

I do not want this coverage.

Buy-Up Option 2

Weekly Benefit

___% of salary to a maximum of \$ _____

I do not want this coverage.

Long-Term Disability (LTD) Coverage :

Core

Monthly benefit

___% of salary to a maximum of \$ _____

I do not want this coverage.

Buy Up

Monthly Benefit

___ % of salary to a maximum of \$ _____

I do not want this coverage.

Signature

- An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in the vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that my dependent(s) cannot be enrolled for a coverage, if I am not enrolled for that coverage.
- You must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations. You must be legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of insurability. Guardian has the right to reject your request.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues, if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of Guardian coverage related documents, in lieu of paper copies, to the extent permitted by applicable law. I voluntarily agree to that arrangement. I do not agree to that arrangement. I understand that I may change this election by providing Guardian 30 days prior written notice.
- I state that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits. (Does not apply to Life Insurance.)

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: 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. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ DATE _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the forms, as a substitute for fraud warnings that appear in other areas of the claim form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.