GUARDIAN®

The Guardian Life Insurance Company of America
And its Affiliates and Subsidiaries

P.O. Box 14319
Lexington, KY 40512

Enrollment/Change Form

Please print clearly and mark carefully.

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

PLEASE CHECK APPROPRIATE BOX

☐ Initial Enrollment ☐ Re-Enrollment ☐ Add Employee/ Dependents ☐ Drop/Refuse Coverage ☐ Information Change
☐ Increase Amount ☐ Family Status Change

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

About You:

First, MI, Last Name:	**Social Security Number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Address/City/State/Zip:	
Gender: M ☐ F ☐ Date of Birth (mm-dd-yy): _____ - _____ - _____	Phone: ( ) -
Email Address:	
Are you married or do you have a spouse/domestic partner? ☐ Yes ☐ No Do you have children or other dependents? ☐ Yes ☐ No	Date of marriage/union: _____ - _____ - _____ Placement date of adopted child: _____ - __-___ - _____

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

Work Status: ☐ Active ☐ Retired ☐ 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.***

		Gender	Date of Birth (mm-dd-yyyy)	
Spouse/domestic partner (First, MI, Last Name)		☐M ☐F	____ - ____ - ____	
Child/Dependent 1:	☐ Add ☐ Drop	Gender ☐M ☐F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 2:	☐ Add ☐ Drop	Gender ☐M ☐F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 3:	☐ Add ☐ Drop	Gender ☐M ☐F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 4:	☐ Add ☐ Drop	Gender ☐M ☐F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

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

	Employee Only	EE & Spouse/domestic partner	EE & Dependent/Child(ren)	EE, Spouse/domestic partner & Dependent/Child(ren)
Option 1 _____	☐	☐	☐	☐
Option 2 _____	☐	☐	☐	☐

☐ 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/domestic partner is covered under another Dental plan.
- ☐ My dependents are covered under another Dental plan.

Basic Life Coverage With Accidental Death and Dismemberment (AD&D):
Check only one box. Benefit reductions apply. Please see plan administrator.

Policy Amount
Employee Only

☐ _____

☐ I do not want this coverage.

NAME YOUR BENEFICIARIES (primary beneficiary percentages must total 100%)
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.)

If this Basic Life policy will replace your existing life insurance coverage 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 With Accidental Death and Dismemberment (AD&D):
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/domestic partner**

☐ ___% 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)**

☐ ___% of employee's amount to maximum $_____

**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.

Long-Term Disability (LTD) Coverage :

Core

Monthly benefit

☐ ____% of salary to a maximum of $____

☐ I do not want this coverage.

Signature

- 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.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- 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 or its designated 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 may change this election only by providing Guardian thirty (30) day prior written notice.
- **I attest that the information provided above is true and correct to the best of my knowledge.**
- **"California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."**

For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment 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: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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.)

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.