GUARDIAN®

• Please Print clearly and in Black or Blue ink • Please Print in Capital Letters only

ENROLLMENT/CHANGE FORM
LIFE/LONG TERM DISABILITY

Planholder Name (Company Name) | **Group Plan Number** | **Division** | **Class**

PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment/Refusal of Coverage (Complete Sections 1, 3, 4, 6) ☐ Add Employee/Dependents (Complete Sections 1, 3, 5, 6) ☐ Drop/Refuse Coverage (Complete Sections 2, 4, 6) ☐ Information Change (Complete Section 6)

SECTION 1

☐ Add Employee
- ☐ New Hire
- ☐ Previously refused this coverage
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Spouse
- ☐ Marriage Date ____/____/____
- ☐ Previously refused this coverage
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Children
- ☐ Newborn
- ☐ Previously refused this coverage
- ☐ Adoption Date ____/____/____
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

SECTION 2

(The date of withdrawal cannot be prior to the date this form is completed and signed.)

☐ Drop Employee (Complete Section 4) ☐ Drop Dependents (Complete Section 4)
- ☐ Termination of Employment *
- ☐ Retirement *
  - *Last Day Worked ____/____/____
  - *Last Day of Coverage ____/____/____
- ☐ Other _____

Last Day of Coverage ____/____/____

SECTION 3

SELECT COVERAGE(S): Dependents cannot be enrolled for coverages refused by the employee.

☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)

☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)

☐ **Long Term Disability** (if applicable, choose one option below)
☐ Buy-Up ☐ Flex AbilityGuard $_____ up to 50% of salary

SECTION 4

REFUSE/DROP COVERAGE(S): (See Refusal on back)

☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)

☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)

☐ **Long Term Disability**

I have been offered the above coverages and wish to refuse/drop enrollment for the followng reasons:

☐ Covered under another insurance plan

☐ Other _____
(additional information may be required)

SECTION 5

LOSS OF OTHER COVERAGE:

I and/or my dependents were previously covered under another group plan. Loss of coverage was due to:

Termination of Employment ____/____/____

Divorce ____/____/____

Death of Spouse ____/____/____

Term./Expiration of Coverage ____/____/____

SECTION 6

Employee Name — Add ☐ Drop ☐ | Last | First | MI | Sex M F | Birth Date (MM DD YYYY) | Social Security Number

Street address | City | State | ZIP

Home Phone: ( ) -

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Are you: ☐ Actively at work ☐ Retired ☐ Other _____ (additional information may be required) Occupation/Job Title:

Number of hours worked per week: | Annual Salary (nearest dollar): | Date of Full Time Hire (MM DD YYYY):

	Add ☐ Drop ☐	Last	First	MI	Sex	Student	Birth Date (MM DD YYYY)	Social Security Number
Spouse Name	☐ ☐				M F			
Child Name	☐ ☐				M F	Y N		
Child Name	☐ ☐				M F	Y N		
Child Name	☐ ☐				M F	Y N		
Child Name	☐ ☐				M F	Y N		

A) Have you included stepchildren? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No

B) Is this your first eligible child? ☐ Yes ☐ No If "no," please list all eligible children above.

Beneficiary Designation: (Include full proper name and relationship) Name: Relationship:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

Signature: _____ Date (MM DD YYYY)

Refusal of Insurance:
If the plan requires contributions, and I have refused the insurance, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and Guardian reserves the right to reject my request.

Agreement:
I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for coverage, or agree that the contributions be added to my dues; (3) state that I became an employee, and do currently work the number of hours per week stated on this form; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. I understand that, in order to be accepted for coverage, my signed and completed application for coverage must be received by Guardian within 31 days of my eligibility for coverage. I authorize any provider, insurer, or other organization to release the necessary information regarding my dental history, treatment or benefits to Guardian or its subsidiary or authorized agent, for the purpose of plan administration.