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

# ENROLLMENT/CHANGE FORM
# MEDICAL/LIFE/DENTAL/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

☐ Drop Employee (Complete Section 4) ☐ Drop Dependents (Complete Section 4)
The date of withdrawal cannot be prior to the date this form is completed and signed.
- ☐ Termination of Employment
- ☐ Retirement
  - Last Day Worked ____/____/____
  - Last Day of Coverage ____/____/____
- ☐ Other _____

## SECTION 3

**SELECT COVERAGE(S):** Dependents cannot be enrolled for coverage refused by the employee.
- ☐ **Medical** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)
- ☐ **Dental** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Vision** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Long Term Disability** (if applicable choose option)
- ☐ **Short Term Disability** (if applicable choose option)

**SELECT COVERAGE OPTIONS:** Choose only one option for each coverage.
- **Medical** ☐ Indemnity ☐ PPO
- **Dental** ☐ Indemnity ☐ PPO ☐ Buy-Up ☐ Pre-Paid * (* Complete Pre-Paid Office # in Section 6)
- **LTD** ☐ Buy-Up ☐ Flex AbilityGuard $____ (up to 50% of salary)
- **STD** ☐ Buy-Up ☐ Flex AbilityGuard $____ (up to 50% of salary)

## SECTION 4

**REFUSE/DROP COVERAGE(S):**
- ☐ **Medical** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)
- ☐ **Dental** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Vision** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Long Term Disability** ☐ **Short Term Disability**

I have been offered the above coverages and wish to refuse/drop enrollment for the following 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 | Pre-Paid Office # (See directory)

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 | Pre-Paid Office # (See directory) |
|---|---|---|---|---|---|---|---|---|---|
| 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) - -

The following applies to health benefit plans unless a state law provides otherwise. For plans that are subject to small group reform, Guardian may require a health statement for Major Medical coverage for the purpose of rating the group and for use in states in which we participate in the reinsurance pool.

## IMPORTANT NOTICE REGARDING YOUR MEDICAL COVERAGE

**SPECIAL ENROLLMENT RIGHTS:** If you are refusing enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan as a new entrant, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents as new entrants, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. You may also enroll as a late enrollee at any time other then for those situations explained above.

**PREEXISTING CONDITION LIMITATION:** This group health benefit plan contains a preexisting condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees). The preexisting condition limitation relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 month period prior to an individual's enrollment date. The exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the preexisting condition limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any preexisting condition limitation will apply to you, you must present your certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health benefit plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health benefit plan, or a health benefit plan issued under the Peace Corps Act.

You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO). If necessary, this plan and Guardian will assist you in obtaining a certificate from any of these entities.

This Preexisting Condition Limitation notice is being issued to you pursuant to the Federal Health Insurance Portability and Accountability Act of 1996 and reflects the protection afforded under federal law. If the state law applicable to a fully insured Guardian plan is more beneficial to covered individuals as to the length of the preexisting condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Guardian plan.

If the plan requires contributions, and I have refused life or disability 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.

Proof of insurability does not apply to dental, but I will be considered a late entrant and my dental benefits will be limited for specific periods of time. However, I and/or my dependents will not be subject to late entrant penalties if dental coverage under another plan is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or where a court has ordered coverage be provided for an eligible spouse or eligible minor child(ren), and application for this plan and documentation of the loss of other coverage is received within 31 days of the termination of such coverage.

** The Pre-Paid dental plan refers to (a) DHMO's which are underwritten by Managed Dental Care of California or Managed DentalGuard or; (b) Managed DentalGuard plans underwritten by The Guardian Life Insurance Company of America. Please consult your Plan Administrator for the plan available to you. The late entrant provision does not apply to Pre-Paid dental benefits. Eligibility for this coverage is only available at the open enrollment period.

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.