GUARDIAN® **The Guardian Life Insurance Company of America**

Enrollment/Change Form

The Guardian Life Insurance Company of America underwrites group term life, accidental death and dismemberment, short term disability, long term disability, critical illness, dental and vision coverages.

Managed DentalGuard, Inc.
Managed DentalGuard, Inc. underwrites group capitated dental coverage.

☐ Northeast Regional Office
P.O. Box 26050, Lehigh Valley, PA 18002-6050

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 ☐ F ☐ Date of Birth (mm-dd-yy): _______ - _______ - _______ Phone: ( ) -

Email Address:

Are you married or do you have a spouse? ☐ Yes ☐ No Date of marriage/union: ______ - ______ - ______
Do you have children or other dependents? ☐ Yes ☐ No 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: $______________ Do not include bonus/commissions

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 ☐M ☐F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
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 State of Residence: ______________
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 State of Residence: ______________
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 State of Residence: ______________
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 State of Residence: ______________

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)
Idemnity	☐	☐	☐	☐
PPO	☐	☐	☐	☐
Buy Up	☐	☐	☐	☐
PrePaid	☐	☐	☐	☐

- **If PrePaid is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit guardianlife.com for a list of providers. If you do not select a PCD, one will be assigned for you.**

Employee__________________________________ Spouse ________________________________ Child(ren) __________________________

☐ 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 & pendent/Child(ren)
☐	☐	☐	☐

☐ 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.

Basic Life Coverage With Accidental Death and Dismemberment (AD&D): ***You must be enrolled to cover your dependents.***
Check only one box in each column.
Employees age 65+ Benefit reductions apply. Please see plan administrator.

Employee Only	Spouse	Child/Dependent	NAME YOUR BENEFICIARIES (primary beneficiary percentages must total 100%)
☐ ☐ I do not want this coverage.	☐ ****The amount may not be more than 50%of the employee amount*** ☐ I do not want this coverage.	☐ ****The amount may not be more than 10% of the employee amount.*** ☐ I do not want this coverage.	**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 coverage.
$ ________________

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): ***You must be enrolled to cover your dependents.***
Check only one box in each column.
Employees age 65+ Benefit reductions apply. Please see plan administrator.

Employee Amount Elected	*Add* Voluntary Life for Spouse	*Add* Voluntary Life for Dependent/Child(ren)
☐ $25,000* ☐ $50,000** ☐ $75,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 **Guarantee Issue Amount* (5+ employees; $10,000 Guarantee Issue ages 65-69) *** 25,000 Guarantee Issue + $25,000 Conditional Issue (5+ employees)* *3 or 4 employees: up to $50,000 Conditional Issue* ☐ I do not want this coverage.	☐ 10,000 ☐ $20,000 ☐ $25,000 Conditional issue all amounts ☐ I do not want this coverage.	☐ 10,000 Conditional issue ☐ I do not want this coverage.

Have you used any form of tobacco in the past 6 months (e.g. pipe, chewing tobacco) and/or have you smoked cigarettes in the past 12 months?
Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

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:

Weekly Benefit

☐ I elect this coverage

☐ I do not want this coverage.

Long-Term Disability (LTD) Coverage :

Monthly benefit

☐ I elect this coverage

☐ 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 the premium amounts shown above are estimations and are for illustrative purposes only.
- 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 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.**

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

The laws of New York require the following statement appear.If you are not a resident of New York this statement does not apply to you: 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** __________

The requested activity is believed eligible and is approved by the Employer.

SIGNATURE OF EMPLOYER REPRESENTATIVE X______________________________ **DATE** __________

REPRESENTATIVE'S TITLE: ______________________________

Enrollment kit ## #### ###

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form. These statements apply only to residents of the noted States.

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 and 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.

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.

INSTRUCTIONS

Employers - You must complete the Policyholder and Signature sections in order for this application to be processed.
Employees - You must complete all sections that apply to you and your dependents including the Signature section in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, select Disabled in Section E, and attach proof of disability.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.

CONDITIONS OF ENROLLMENT - EMPLOYEE ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Guardian, or any consumer reporting agency acting on behalf of Guardian, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Guardian has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Guardian will provide coverage in accordance with the terms of the contract for the group plan.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.