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: ______________<br>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:<br>☐ Active ☐ Retired ☐ Cobra/State Continuation | Date of full time hire:<br>_____ - _____ - _____ | Annual Salary: $________________<br>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<br>☐M<br>☐F | Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | |
| Child/Dependent 1: | ☐ Add<br>☐ Drop | Gender<br>☐M<br>☐F | Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br>☐ Student (post high school) ☐ Disabled<br>☐ Non standard dependent<br>State of Residence: ______________ |
| Child/Dependent 2: | ☐ Add<br>☐ Drop | Gender<br>☐M<br>☐F | Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br>☐ Student (post high school) ☐ Disabled<br>☐ Non standard dependent<br>State of Residence: ______________ |
| Child/Dependent 3: | ☐ Add<br>☐ Drop | Gender<br>☐M<br>☐F | Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br>☐ Student (post high school) ☐ Disabled<br>☐ Non standard dependent<br>State of Residence: ______________ |
| Child/Dependent 4: | ☐ Add<br>☐ Drop | Gender<br>☐M<br>☐F | Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br>☐ Student (post high school) ☐ Disabled<br>☐ Non standard dependent<br>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.

**Signature**

- 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 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:** ______________________________________________