GUARDIAN®

The Guardian Life Insurance Company of America
And its Affiliates and Subsidiaries
Midwest Regional Office
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 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: $_____

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 dependent tax exemption. Dependent 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/domestic partner (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender ☐M ☐F	Social Security Number ___-___-___ Date of Birth (mm-dd-yyyy) ___-___-___	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐M ☐F	Social Security Number ___-___-___ Date of Birth (mm-dd-yyyy) ___-___-___	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐M ☐F	Social Security Number ___-___-___ Date of Birth (mm-dd-yyyy) ___-___-___	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐M ☐F	Social Security Number ___-___-___ Date of Birth (mm-dd-yyyy) ___-___-___	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐M ☐F	Social Security Number ____ - ____ - ____ 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)
_____	☐	☐	☐	☐

- **if Pre Paid/DHMO 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/domestic partner _____ 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 mus 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)
_____	☐	☐	☐	☐

☐ I do not want his 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:
Benefit reductions apply. Please see plan administrator.
Policy Amount
Employee Only
☐ Employer Paid

If this Basic Life policy will replace your existing life insurance policy 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

Name your beneficiaries: (primary beneficiary percentages must total 100%)
Primary Beneficiaries:

Name: _____ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **%** _____

Address/City/State/Zip: _____

Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) - Relationship to employee: _____

Name: _____ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **%** _____

Address/City/State/Zip: _____

Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) - Relationship to employee: _____

Contingent Beneficiary:

Name: _____ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **%** _____

Address/City/State/Zip: _____

Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) - Relationship to employee: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.).

Voluntary Term Life Coverage: ***Check only one box.***

Benefit reductions apply. Please see plan administrator.

Insurance Amount :	Spouse/domestic partner	Child/Dependent
☐ $_____	☐ $_____	☐ $_____
(Benefit amount may not exceed $1,000,000 when combined with Permanent Life.)	***The amount may not be more than 50% of the employee amount of Voluntary Life.***	****The amount may not be more than 10% of the employee amount of Voluntary Life.***
☐ I do not want this coverage.	☐ I do not want this coverage.	☐ I do not want this coverage.

If this Basic Life policy will replace your existing life insurance policy 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 Voluntary Life.

Employee - Name your beneficiaries: (primary beneficiary percentages must total 100%)

Primary Beneficiaries:

Name: _____ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **%** _____

Date of Birth (mm-dd-yy): ____ - ____ - ____ Address/City/State/Zip: _____

Phone: ( ) - Relationship to employee: _____

Name: _____ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **%** _____

Date of Birth (mm-dd-yy): ____ - ____ - ____ Address/City/State/Zip: _____

Phone: ( ) - Relationship to employee: _____

Contingent Beneficiary Name: _____ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **%** _____

Date of Birth (mm-dd-yy): ____ - ____ - ____ Address/City/State/Zip: _____

Phone: ( ) - Relationship to employee: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Voluntary Permanent Life Coverage: Check only one box.

Benefit Amount : Check one box only	**Add Permanent Life for Spouse**	**Add Permanent Life for Dependent/Child(ren)**
☐ $_____	☐ **$**_____	**Please see cost illustration for premium and cash value amounts.**
(Benefit amount may not exceed: (a) $500,000 and (b) $1,000,000 when combined with Voluntary Term Life.)	***The amount may not be more than 50% of the employee amount of Permanent Life.***	☐ Dep 1 ☐ Dep 2 ☐ Dep 3 ☐ Dep 4
☐ I do not want this coverage.	☐ I do not want this coverage.	☐ $_____
Please see cost illustration for premium and cash value amounts.	**Add Spouse Term Coverage**	****The amount may not be more than 10% of the employee amount of Permanent Life.***
	☐ $_____	☐ I do not want this coverage.
	(The amount may not be more than 50% of the employee amount for Permanent Life.)	**Add Child(ren) Term coverage**
	☐ I do not want this coverage.	☐ Dep 1 ☐ Dep 2 ☐ Dep 3 ☐ Dep 4
		☐ $_____
		☐ 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

Child (age 18 or older) ☐ Dep 1 ☐ Yes ☐ No ☐ Dep 3 ☐ Yes ☐ No

☐ Dep 2 ☐ Yes ☐ No ☐ Dep 4 ☐ Yes ☐ No

Important Notes:

Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Permanent 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: _____ **Social Security Number:** __ __ __ - __ __ - __ __ __ __ **%** _____

Address/City/State/Zip: _____

Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) - Relationship to employee: _____

Name: _____ **Social Security Number:** __ __ __ - __ __ - __ __ __ __ **%** _____

Address/City/State/Zip: _____

Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) - Relationship to employee: _____

Contingent Beneficiary:

Name: _____ **Social Security Number:** __ __ __ - __ __ - __ __ __ __ **%** _____

Address/City/State/Zip: _____

Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) - Relationship to employee: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.).

Short -Term Disability (STD) Coverage:	**DI Choice Coverage (Amount):**	**DI Standard Coverage (%):**
Weekly Benefit ☐ Employer Paid ☐ I do not want this coverage.	Weekly Benefit **Amount** ☐ $_____ This amount may not exceed 60% of your weekly salary. ☐ I do not want this coverage.	Weekly Benefit **Flat Percentage** ☐ ____% of salary to maximum $_____ ☐ I do not want this coverage.
Long -Term Disability (LTD) Coverage:	**DI Choice Coverage (Amount):**	**DI Standard Coverage (%):**
Monthly Benefit ☐ Employer Paid ☐ I do not want this coverage.	Monthly Benefit **Amount** ☐ $_____ This amount may not exceed 60% of your monthly salary. ☐ I do not want this coverage.	Monthly Benefit **Flat Percentage** ☐ ____% of salary to maximum $_____ ☐ I do not want this coverage.

Critical Illness Coverage:
Benefit reductions apply. Please see plan administrator.

TO BE ELIGIBLE FOR THIS COVERAGE, YOU MUST HAVE COMPREHENSIVE HEALTH BENEFITS FROM AN INSURANCE POLICY, AN HMO PLAN, OR AN EMPLOYER HEALTH BENEFIT PLAN. PERSONS WITHOUT SUCH COVERAGE ARE NOT ELIGIBLE FOR THIS COVERAGE.

Do you have, on the date of this application, at least major medical insurance or at least hospital insurance and basic medical insurance (required underlying medical coverage) in force for yourself and any dependents being enrolled?

Employee: ___ Yes ___ No
Spouse: ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
Child(ren): ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
For a "Yes" response, proceed to the next section. For any "No" response, a certificate will not be issued.

NOTE: THIS COVERAGE IS NOT AVAILABLE TO ANY PERSON WHO IS 1) 65 YEARS OF AGE OR OLDER AND IS COVERED BY MEDICARE PART A AND PART B AND A MEDICARE SUPPLEMENT INSURANCE POLICY, CERTIFICATE, OR CONTRACT FOR COVERAGE OF EXCESS CHARGES UNDER MEDICARE PART B, OR 2) 65 YEARS OF AGE OR OLDER, IF PURCHASING THIS COVERAGE WOULD RESULT IN COVERAGE FOR MEDICAL BENEFITS FOR MORE THAN 100% OF ACTUAL MEDICAL EXPENSES.

On the date of this application, do you or a dependent spouse meet the conditions listed in either item 1 or 2 in the "Note" above? For any "Yes" response, a certificate will not be issued.

Employee: ___ Yes ___ No
Spouse: ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
Child(ren): ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
For a "No" response, proceed to the next section. For any "Yes" response, a certificate will not be issued

Core	**Spouse**	**Dependent/Child(ren)**
Insurance Amount : ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 ☐ _____ ☐ I do not want this coverage.	Insurance Amount ☐ _____ **The amount may not be more than 50% of Employee Amount.** ☐ I do not want this coverage.	Insurance Amount: ☐ _____ **The amount may not be more than 25% of Employee Amount.** ☐ I do not want this coverage.

If you or your dependent spouse elect Critical Illness Coverage, you must answer the following health questions.

1. Has any proposed insured been diagnosed with or treated by a medical professional for any of the following conditions: cancer, carcinoma in situ, malignant melanoma, tumor (benign or malignant), Barrett's esophagus, Crohn's disease, ulcerative colitis, blood disorder (other than AIDS or HIV), any chronic or progressive disease of kidneys, liver (including hepatitis), lungs, including emphysema and COPD, pancreas or bone marrow? Or, been advised to have an organ transplant, including bone marrow or stem cell transplant?
   Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No
2. Has any proposed insured been diagnosed with or treated by a medical professional for heart attack, heart disease or coronary artery disease, stroke or transient ischemic attack (TIA), or been advised to have bypass surgery, stent insertions treatment for coronary arteries?
   Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No
3. Has any proposed insured been diagnosed with or treated by a medical professional for uncontrolled blood pressure (requiring a change in medication or dosage in the past 6 months or been diagnosed with or treated for diabetes (except if present only in pregnancy)?
   Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No
4. Has any proposed insured been diagnosed with or treated by a medical professional for any progressive vision, speech or hearing disorder, or dementia (including Alzheimer's disease) or any neurological disease or disorder, including seizures, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), Huntington's disease, Multiple Sclerosis or Parkinson's Disease?
   Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No
5. Has any proposed insured been diagnosed with or treated by a medical professional for AIDS (acquired immune deficiency syndrome), AIDS-Related Complex or tested positive for HIV (human immunodeficiency virus)?
   Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Important Notes:

- Based on your plan benefits and age you may be required to complete an additional evidence of insurability form for Critical Illness.

Accident 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)
	☐	☐	☐	☐

☐ I do not want this coverage.

Name your beneficiaries: (primary beneficiary percentages must total 100%)

Primary Beneficiaries:

Name: _____ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **%** _____
Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____
Phone: ( ) - Relationship to employee: _____

Name: _____ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **%** _____
Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____
Phone: ( ) - Relationship to employee: _____

Contingent Beneficiary Name: _____ **Social Security Number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **%** _____
Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____
Phone: ( ) - Relationship to employee: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

TO BE ELIGIBLE FOR THIS COVERAGE, YOU MUST HAVE COMPREHENSIVE HEALTH BENEFITS FROM AN INSURANCE POLICY, AN HMO PLAN, OR AN EMPLOYER HEALTH BENEFIT PLAN. PERSONS WITHOUT SUCH COVERAGE ARE NOT ELIGIBLE FOR THIS COVERAGE

Do you have, on the date of this application, at least major medical insurance or at least hospital insurance and basic medical insurance (required underlying medical coverage) in force for yourself and any dependents being enrolled?
Employee: ___ Yes ___ No
Spouse: ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
Child(ren): ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
For a "Yes" response, proceed to the next section. For any "No" response, a certificate will not be issued.

NOTE: THIS COVERAGE IS NOT AVAILABLE TO ANY PERSON WHO IS 1) 65 YEARS OF AGE OR OLDER AND IS COVERED BY MEDICARE PART A AND PART B AND A MEDICARE SUPPLEMENT INSURANCE POLICY, CERTIFICATE, OR CONTRACT FOR COVERAGE OF EXCESS CHARGES UNDER MEDICARE PART B, OR 2) 65 YEARS OF AGE OR OLDER, IF PURCHASING THIS COVERAGE WOULD RESULT IN COVERAGE FOR MEDICAL BENEFITS FOR MORE THAN 100% OF ACTUAL MEDICAL EXPENSES.

On the date of this application, do you or a dependent spouse meet the conditions listed in either item 1 or 2 of the "Note" above? For any "Yes" response, a certificate will not be issued.
Employee: ___ Yes ___ No
Spouse: ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
Child(ren): ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
For a "No" response, proceed to the next section. For any "Yes" response, a certificate will not be issued

Cancer 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)
_____	☐	☐	☐	☐

☐ I do not want this coverage.

Complete the following question if you are enrolling for Cancer coverage. NOTE: Additional information may be required.

Has anyone to be covered been treated for or diagnosed by a licensed medical professional as having Cancer in any form within the last 5 years?

☐ Yes, I have. ☐ No, I haven't. ☐ Yes, my spouse/domestic partner has. ☐ No, my spouse/domestic partner hasn't.

☐ Yes, my dependent child(ren) have. ☐ No, my child(ren) haven't.

To the best of your knowledge, has anyone to be covered been treated for or diagnosed by a medical professional as having AIDS Related Complex (ARC) or AIDS within the last 5 years?

☐ Yes, I have. ☐ No, I haven't. ☐ Yes, my spouse/domestic partner has. ☐ No, my spouse/domestic partner hasn't.

☐ Yes, my dependent child(ren) have. ☐ No, my child(ren) haven't.

TO BE ELIGIBLE FOR THIS COVERAGE, YOU MUST HAVE COMPREHENSIVE HEALTH BENEFITS FROM AN INSURANCE POLICY, AN HMO PLAN, OR AN EMPLOYER HEALTH BENEFIT PLAN. PERSONS WITHOUT SUCH COVERAGE ARE NOT ELIGIBLE FOR THIS COVERAGE.

Do you have, on the date of this application, at least major medical insurance or at least hospital insurance and basic medical insurance (required underlying medical coverage) in force for yourself and any dependents being enrolled?
Employee: ___ Yes ___ No
Spouse: ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
Child(ren): ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
For a "Yes" response, proceed to the next section. For any "No" response, a certificate will not be issued.

NOTE: THIS COVERAGE IS NOT AVAILABLE TO ANY PERSON WHO IS 1) 65 YEARS OF AGE OR OLDER AND IS COVERED BY MEDICARE PART A AND PART B AND A MEDICARE SUPPLEMENT INSURANCE POLICY, CERTIFICATE, OR CONTRACT FOR COVERAGE OF EXCESS CHARGES UNDER MEDICARE PART B, OR 2) 65 YEARS OF AGE OR OLDER, IF PURCHASING THIS COVERAGE WOULD RESULT IN COVERAGE FOR MEDICAL BENEFITS FOR MORE THAN 100% OF ACTUAL MEDICAL EXPENSES.

On the date of this application, do you or a dependent spouse meet the conditions listed in either item 1 or 2 in the "Note" above? For any "Yes" response, a certificate will not be issued.
Employee: ___ Yes ___ No
Spouse: ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
Child(ren): ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
For a "No" response, proceed to the next section. For any "Yes" response, a certificate will not be issued.

Hospital Indemnity 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)
_____	☐	☐	☐	☐

Applicants over the age of 69 are not eligible to enroll in Hospital Indemnity coverage.

☐ I do not want this coverage.

Important Notes:

TO BE ELIGIBLE FOR THIS COVERAGE, YOU MUST HAVE COMPREHENSIVE HEALTH BENEFITS FROM AN INSURANCE POLICY, AN HMO PLAN, OR AN EMPLOYER HEALTH BENEFIT PLAN. PERSONS WITHOUT SUCH COVERAGE ARE NOT ELIGIBLE FOR THIS COVERAGE.

Do you have, on the date of this application, at least major medical insurance or at least hospital insurance and basic medical insurance (required underlying medical coverage) in force for yourself and any dependents being enrolled?

Employee: ___ Yes ___ No
Spouse: ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
Child(ren): ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent

For a "Yes" response, proceed to the next section. For any "No" response, a certificate will not be issued.

NOTE: THIS COVERAGE IS NOT AVAILABLE TO ANY PERSON WHO IS 1) 65 YEARS OF AGE OR OLDER AND IS COVERED BY MEDICARE PART A AND PART B AND A MEDICARE SUPPLEMENT INSURANCE POLICY, CERTIFICATE, OR CONTRACT FOR COVERAGE OF EXCESS CHARGES UNDER MEDICARE PART B, OR 2) 65 YEARS OF AGE OR OLDER, IF PURCHASING THIS COVERAGE WOULD RESULT IN COVERAGE FOR MEDICAL BENEFITS FOR MORE THAN 100% OF ACTUAL MEDICAL EXPENSES.

On the date of this application, do you or a dependent spouse meet the conditions listed in either item 1 or 2 in the "Note" above? For any "Yes" response, a certificate will not be issued.

Employee: ___ Yes ___ No
Spouse: ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent
Child(ren): ___ Yes ___ No ____ N/A* * Select N/A only if not enrolling this dependent

For a "No" response, proceed to the next section. For any "Yes" response, a certificate will not be issued.

Health History:

Complete the following question if you are enrolling for one or more of the following benefits listed below and you are electing an amount above coverage that is Guaranteed Issue. NOTE: Additional information may be required.

Basic Life Insurance Voluntary Life Insurance

To the best of your knowledge, in the last 6 months have you or any of your dependents been diagnosed with or treated by a medical professional for or had a study done for which medical results are pending for; or taken prescribed drugs for: Cancer, (except localized non melanoma skin cancer), Heart disease, or Diabetes?

☐ Yes, I have. ☐ No, I haven't. ☐ Yes, my spouse/domestic partner has. ☐ No, my spouse/domestic partner hasn't.
☐ Yes, my dependent child(ren) have. ☐ No, my child(ren) haven't.

To the best of your knowledge, have you or any of your dependents] been treated for or diagnosed by a medical professional as having AIDS Related Complex (ARC) or AIDS?

☐ Yes, I have. ☐ No, I haven't. ☐ Yes, my spouse/domestic partner has. ☐ No, my spouse/domestic partner hasn't.
☐ Yes, my dependent child(ren) have. ☐ No, my child(ren) haven't.

An Evidence of Insurability form must be completed for any person with a "Yes" answer to the question above.

Signature

- An employee's decision to elect Vision and/or Hospital Indemnity or not elect Vision and/or Hospital Indemnity must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in the Vision and/or Hospital Indemnity 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 my dependent(s) cannot be enrolled for a coverage, if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- 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 each person's insurability. Guardian or its designee 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 apply premiums to my credit card or debit card, 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 applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I understand that California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.
- **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, Nebraska and Oregon: 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.

Kansas: 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 insurance fraud as determined by a court of law.

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 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.

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

Vermont: It is a crime for any person knowingly to provide material false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, for any person knowingly to provide material false, incomplete, or misleading information concerning the sale of insurance or the status of an insurer, or for any person to misappropriate the funds of an insured or an applicant for insurance. Penalties include imprisonment, fines, and denial of insurance benefits.

Virginia: Any person who, with the 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 have violated state law.