Guardian Life Insurance Company of America
Group Insurance Enrollment Form

Check reason for completing form:

Western Regional Office
PO Box 2454
Spokane, WA 99210-2454

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

☐ New Subscriber ☐ Delete Coverage ☐ Add a Family Member
☐ Change Address ☐ Change Name ☐ Terminate a Family Member
Date of Change ____________ Reason for Change____________________________

PLANHOLDER NAME (COMPANY NAME)		GROUP PLAN NO.	DIVISION
PLANHOLDER STREET ADDRESS	CITY	STATE	ZIP

EMPLOYEE INFORMATION ***(PLEASE PRINT LEGIBLY AS THIS INFORMATION WILL BE DIRECTLY INPUT INTO OUR SYSTEM)***

FIRST NAME	MIDDLE	LAST NAME	SOC. SEC. NO.	BIRTHDATE	SEX

EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP	SALARY

OCCUPATION/JOB TITLE	CLASS	DATE OF FULL-TIME EMPLOYMENT	HOURS WORKED PER WEEK

MARITAL STATUS:
☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

DEPENDENT CHILDREN? ☐ Yes ☐ No

COVERAGE ELECTION

DENTAL / VISION **EMPLOYEE:** ☐ **I elect coverage.** **SPOUSE:** ☐ Yes ☐ No** **CHILD(REN):** ☐ Yes ☐ No**

☐ **I decline coverage** (this also waives **ALL** dependent Dental coverage). I understand if I elect coverage at a later date, late entrant penalties will apply.*

* If declining coverage, are you covered under another Dental plan? ☐ Yes ☐ No

** If declining dependent coverage, are your dependents covered under another Dental plan? ☐ Yes ☐ No

DEPENDENT INFORMATION

NAME FIRST, MIDDLE INITIAL, LAST		SEX	RELATIONSHIP	BIRTHDATE	STUDENT
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No

Are any dependent children adopted? ☐ Yes ☐ No If "yes," indicate name and date of adoption: ________________________________

Have you included stepchildren as dependents? ☐ Yes ☐ No If "yes," indicate name(s): ____

Do your stepchildren reside with you? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No

EMPLOYEE BENEFICIARY DESIGNATION (Include full proper name and relationship; i.e.: Mary A. Jones, wife.)

NAME	RELATIONSHIP

I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make necessary deductions for the contributions, if any, required for insurance, or agree that the contributions be added to my dues; (3) state that I became an employee on the date stated above, and do currently work the number of hours per week stated above; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. 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. I have reviewed the statements on this application and they are true and complete.

SIGNATURE OF EMPLOYEE	DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO THE GUARDIAN

IMPORTANT NOTICE

Unless state law provides otherwise, the following apply to health plans issued or renewed on or after July 1, 1997:

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 entrant at any time other than for those situations explained above.

PRE-EXISTING CONDITION LIMITATION:

This plan imposes a pre-existing condition exclusion exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior “credible coverage”. Most prior health coverage is credible coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18 month) exclusion period by your credible coverage, you should give us a copy of any certificates of credible coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have credible coverage. Please contact us if you need help demonstrating credible coverage.

All questions about the pre-existing condition exclusion and credible coverage should be directed to our Member Services Department at P.O. Box 8008 Appleton WI 54912 or 1-800-873-4542.

This Pre-existing Condition Limitation notice is being issued 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 pre-existing condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Guardian plan.

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. 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.