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

Enrollment/Change Form

Guardian Group Plan Number:	
Employer:	Plan Administrator:

EMPLOYER USE ONLY	☐ New Enrollment. ☐ Add Dependent(s). ☐ Drop Dependent(s). ☐ Change Address. ☐ Change Name. ☐ Drop Coverage as of: / /		
Class:	Hours Worked:	Division:	Payroll Period:
Date Form Published:	Pay Periods Per Year:	Payroll Change Effective:(MM/DD/YR)	Benefits Effective: (MM/DD/YR)

Keep a copy for your records and return form to: Northeast Regional Office; P.O. Box 26040; Lehigh Valley, PA; 18002-6040 or Midwest Regional Office; P.O. Box 8012; Appleton, WI; 54912-8012 or Western Regional Office; P.O. Box 2454; Spokane, WA; 99210-2454

EMPLOYEE **Please provide this information about YOURSELF.**
Please Print Clearly and in Black or Blue Ink.

☐ Drop First, Middle Initial, Last Name	Sex ☐ M ☐ F	Date of Birth (MM/DD/YR)	Social Security Number
Address	City	State	Zip
Preferred Email	Day Phone:	Evening Phone:	The best way to reach you: ☐ Day Phone ☐ Evening Phone ☐ Email
Job Title:	Work Status/Eligibility: ☐ Full Time. ☐ Part Time. ☐ Retired. ☐ Cobra/State Continuation. Since: (MM/DD/YR)		Annual Salary/Earnings: $__________.

Are you married? ☐ Yes ☐ No

Do you have children or other dependents? ☐ Yes ☐ No

DEPENDENTS **Provide this information about your DEPENDENTS.**

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 exemption. 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.

		Sex:	DOB: (MM/DD/YR)	Social Security Number:	
☐ Drop	Spouse/Domestic Partner (DP) First Name, Middle Initial, Last Name:	☐ M ☐ F	DOB: (MM/DD/YR)	Social Security Number:	Date of Marriage: (MM/DD/YR)
☐ For Federal reporting purposes, please check this box if Spouse is a Domestic Partner.					
☐ Drop	Child 1:	Sex: ☐ M ☐ F	DOB: (MM/DD/YR)	Social Security Number:	☐ Full-Time Student, at (school, city, state): Since (MM/DD/YR:
☐ Drop	Child 2:	Sex: ☐ M ☐ F	DOB: (MM/DD/YR)	Social Security Number:	☐ Full-Time Student, at (school, city, state): Since (MM/DD/YR):
☐ Drop	Child 3:	Sex: ☐ M ☐ F	DOB: (MM/DD/YR)	Social Security Number:	☐ Full-Time Student, at (school, city, state): Since (MM/DD/YR):
☐ Drop	Child 4:	Sex: ☐ M ☐ F	DOB: (MM/DD/YR)	Social Security Number:	☐ Full-Time Student, at (school, city, state): Since (MM/DD/YR):

☐ A sheet with information about additional dependents is attached.

To drop coverage for yourself or your dependents, check the box(es) to the left of the name(s) and select the coverage(s) to drop. Attach a separate sheet if you wish to drop more than one dependent from different coverages. ☐ Medical

CEF2005

MEDICAL with Prescription Drug				**Choose your Medical coverage.** *Check one box only. If you wish to waive coverage for yourself or your dependents, you must check appropriate box (es).*
Find medical providers online at www.guardianlife.com or check the directory of providers.				
	Employee Alone	**Employee & Spouse**	**Employee & Child (ren)**	**Entire Family**
Medical Plan 1	☐	☐	☐	☐
Medical Plan 2	☐	☐	☐	☐
Medical Plan 3	☐	☐	☐	☐
	☐ I Waive This Coverage.	☐ I Waive This Coverage.	☐ I Waive This Coverage.	☐ I Waive This Coverage.

Deduct premiums: ☐ After Taxes. ☐ Before Taxes. (Check with your Employer for details.)

Does another carrier or Medicare cover you or your dependents for medical insurance? ☐ Yes. ☐ No. If "Yes.", please provide the following:

Name of your other carrier:	Plan Number:	Effective Date: (MM/DD/YR)	Carrier's phone number:
Spouse's:		(MM/DD/YR)	
Child(ren)'s:		(MM/DD/YR)	

☐ Additional carriers for other dependents are included on a separate sheet.

If you or your family has lost medical coverage, please explain below. *Special enrollment rights apply.*

Reason for Loss of coverage: ☐Termination of Employment. ☐ Divorce. ☐ Death of Spouse. ☐ Termination or Expiration of coverage.	Date of coverage loss: (MM/DD/YR)

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

- Special Enrollment Rights: If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you apply for 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, provided that you request enrollment within 30 days of the marriage, birth adoption or placement for adoption. You may also enroll as a late enrollee at any time other than for those situations explained above.
- Pre-existing Condition Limitation: This plan imposes a pre-existing condition 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 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or 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 6 months (18 months for late enrollees) from the date of a person's enrollment, 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 "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if such creditable coverage was continuous to a date not more than 90 days before to the effective date of coverage under this plan. To reduce the 6-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable 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 creditable coverage. Please contact us if you need help demonstrating creditable coverage.
- All questions about the pre-existing condition exclusion and creditable coverage should be directed to our Member Services Department at PO Box 8007 Appleton WI 54912 or 1-800-873-4542.
- The Pre-existing 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 pre-existing condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Guardian plan.

SIGNATURE

- I hereby apply for the group coverage(s) that I have chosen above.
- I understand that I must meet the eligibility requirements for all coverages that I have chosen above.
- I understand that my dependent(s) cannot be enrolled for coverage if I am not enrolled for that coverage.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverages I have chosen above.
- I understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
- **I attest that the information provided above is true and correct to the best of my knowledge.**
- **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 may be guilty of insurance fraud.**

SIGNATURE OF EMPLOYEE	DATE

Questions? Call the Employee Benefits Hotline (888) 600-1600