



• Please Print clearly and in Black or Blue ink • Please Print in Capital Letters only

ENROLLMENT/CHANGE FORM LIFE/DISABILITY

Planholder Name (Company Name) Group Plan Number Division Class

PLEASE CHECK APPROPRIATE BOX Initial Enrollment/Refusal of Coverage Add Employee/Dependents Drop/Refuse Coverage Information Change

SECTION 1 and 2: Add Employee, Add Spouse, Add Children, Drop Employee, Drop Dependents, etc.

SECTION 3: SELECT COVERAGE(S): Life, AD&D, Long Term Disability, Short Term Disability

SECTION 4: REFUSE/DROP COVERAGE(S): Life, AD&D, Long Term Disability, Short Term Disability

SECTION 5: LOSS OF OTHER COVERAGE: Termination of Employment, Divorce, etc.

SECTION 6: Employee and Spouse/Child information including Name, Birth Date, Social Security Number, Marital Status, etc.

Beneficiary Designation: (Include full proper name and relationship) Name: Relationship:

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.

Signature: Date (MM DD YYYY)

Refusal of Insurance:

If the plan requires contributions, and I have refused the insurance, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and Guardian reserves the right to reject my request.

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; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. 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.