



Northeast Regional Office  
P.O. Box 26060  
Lehigh Valley, PA 18002-6060

Midwest Regional Office  
P.O. Box 8012  
Appleton, WI 54913-8012

Western Regional Office  
P.O. Box 2454  
Spokane, WA 99210-2454

Norwell Regional Office  
P.O. Box 9121  
Norwell, MA 02061-9121

**Before completing this application, please read the IMPORTANT notice on the reverse side of this form concerning special enrollment rights and preexisting condition limitations.**

PLANHOLDER NAME (COMPANY NAME)		GROUP PLAN NO.	BRANCH
PLANHOLDER STREET ADDRESS		CITY	STATE ZIP
EMPLOYEE NAME (LAST, FIRST, MI) <input type="checkbox"/> MR. <input type="checkbox"/> MISS <input type="checkbox"/> MRS. <input type="checkbox"/> MS.		SOC. SEC. NO.	BIRTH DATE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
EMPLOYEE'S STREET ADDRESS		CITY	STATE ZIP TELEPHONE ( ) -
OCCUPATION/JOB TITLE		DATE OF FULLTIME EMP.	HRS WORKED WK ANNUAL SALARY \$
MARTIAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED		DEPENDENT CHILDREN <input type="checkbox"/> YES <input type="checkbox"/> NO	

**ENROLLMENT FOR INSURANCE** (Complete only for any Guardian coverages desired.)

<b>EMPLOYEE COVERAGE REQUESTED:</b> <input type="checkbox"/> Life/Accidental Death & Dismemberment <input type="checkbox"/> Life (plans without AD&D) <input type="checkbox"/> Optional Life Amount \$ _____ <input type="checkbox"/> Major Medical only (plans without Rx Card) <input type="checkbox"/> Major Medical / Rx Card <input type="checkbox"/> Rx Card only (plans without Major Medical) <input type="checkbox"/> Buy Down Major Medical Ded. \$ _____ <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Electing Buy-up STD Optional STD Weekly Maximum \$ _____ up to 50% of salary <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Electing Buy-up LTD Optional LTD Monthly Maximum \$ _____ up to 50% of salary	<b>DEPENDENT COVERAGE REQUESTED (Dependents cannot be enrolled for coverages declined by the employee.):</b> <input type="checkbox"/> Dependent Life <input type="checkbox"/> Optional Life Amount \$ _____ <input type="checkbox"/> Major Medical only (plans without Rx Card) <input type="checkbox"/> Major Medical / Rx Card <input type="checkbox"/> Rx Card only (plans without Major Medical) <input type="checkbox"/> Dental <input type="checkbox"/> Vision <b>I ELECT DEPENDENT COVERAGE FOR:</b> <input type="checkbox"/> Spouse Only <input type="checkbox"/> Spouse & Child(ren) <input type="checkbox"/> Child(ren) Only
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**Give the following information for each dependent to be insured:**

NAME (LAST, FIRST, MI)	SEX	RELATIONSHIP	SOC. SEC. NO.	BIRTH DATE	STUDENT
	<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> F <input type="checkbox"/> M				<input type="checkbox"/> YES <input type="checkbox"/> 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** (Complete only if enrolling for Life Insurance. Include full proper name and relationship; ie: Mary A Jones, Wife)

NAME	RELATIONSHIP
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**ALTERNATIVE COVERAGE** (Complete only if enrolling in a Health Maintenance Organization [HMO] or Pre-Paid Dental type plan.)

**I Elect:**  
 Medical coverage for myself and dependents under the following HMO plan: \_\_\_\_\_  
 Dental coverage for myself and dependents under the following Pre-Paid Dental plan: \_\_\_\_\_

**REFUSAL OF INSURANCE (Please read the refusal section on reverse)** (Complete only if not enrolling for all available Guardian coverages.)

**I decline the following employee coverage/s available to me:**  
 Life/Accidental Death & Dismemberment.  Life (plans without AD&D)  Optional Life  Major Medical only (plans without Rx Card)  
 Major Medical/Rx Card  Rx Card only (plans without Major Medical)  Dental  Vision  Short Term Dis.  Long Term Dis.  All Coverage  
**because:**  I am insured under another policy or group plan (please indicate information below)  Other reasons  
 Employer's Name: \_\_\_\_\_ Carrier's Name: \_\_\_\_\_  
**I decline the following coverage/s available to my**  spouse only  spouse & child(ren)  child(ren) only:  
 Dependent Life  Optional Life  Major Medical only (plans without Rx Card)  Major Medical/Rx Card  
 Rx Card only (plans without Major Medical)  Dental  Vision  All Coverage  
**because:**  My dependents are insured under another policy or group plan ( please indicate information below)  Other reasons  
 Employer's Name: \_\_\_\_\_ Carrier's Name: \_\_\_\_\_

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 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 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.  
 I have reviewed the statements on this application and they are true and complete.

SIGNATURE OF EMPLOYEE	SIGNATURE OF WITNESS (only required if employee signature is "X")	DATE
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**FOR GUARDIAN USE ONLY** (Indicate coverages and amounts.)

EMPLOYEE:	Class	Eff. Date	<input type="checkbox"/> Life (w/AD&D)	<input type="checkbox"/> Life (w/o AD&D)	<input type="checkbox"/> Optional Life
	<input type="checkbox"/> WLT <input type="checkbox"/> SLT	<input type="checkbox"/> Rx Card	<input type="checkbox"/> Major Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
DEPENDENT:	<input type="checkbox"/> Life	<input type="checkbox"/> Optional Life	<input type="checkbox"/> Rx Card	<input type="checkbox"/> Major Medical	<input type="checkbox"/> Dental
				<input type="checkbox"/> Dental	<input type="checkbox"/> Vision

PLEASE SUBMIT THE ORIGINAL AND FIRST COPY TO GUARDIAN,  
 MAINTAIN THE SECOND COPY FOR YOUR RECORDS.

## 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 declining 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, 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, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

### **PREEXISTING CONDITION LIMITATION:**

This group health plan contains a preexisting condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees). The preexisting condition limitation relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 month period prior to an individual's enrollment date. This exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the preexisting condition limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any preexisting condition limitation will apply to you, you must present your certificate or certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, or a health plan issued under the Peace Corps Act.

You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO). If necessary, this plan and Guardian will assist you in obtaining a certificate from any of these entities.

**This Preexisting 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 the preexisting condition limitation and permissible break in coverage, the relevant state provisions will apply to and be part of your Guardian plan.**

### **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. Proof of insurability does not apply to major medical, dental or vision coverages. However, late entrant penalties may apply to major medical and dental and enrollment delays may apply to vision. Refer to Special Enrollment Rights on the reverse for additional information.