GUARDIAN®

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

ENROLLMENT/CHANGE FORM

Planholder Name (Company Name) | **Group Plan Number** | **Division** | **Class**

PLEASE CHECK APPROPRIATE BOX ☐ **Initial Enrollment/Refusal of Coverage (Complete Sections 1, 3, 4, 6)** ☐ **Add Employee/Dependents (Complete Sections 1, 3, 5, 6)** ☐ **Drop/Refuse Coverage (Complete Sections 2, 4, 6)** ☐ **Information Change (Complete Section 6)**

SECTION 1

☐ Add Employee
- ☐ New Hire
- ☐ Previously refused this coverage
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Spouse
- ☐ Marriage Date ____/____/____
- ☐ Previously refused this coverage
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Children
- ☐ Newborn
- ☐ Previously refused this coverage
- ☐ Adoption Date ____/____/____
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

SECTION 2

☐ Drop Employee (Complete Section 4) ☐ Drop Dependents (Complete Section 4)

The date of withdrawal cannot be prior to the date this form is completed and signed.
- ☐ Termination of Employment
- ☐ Retirement
  - Last Day Worked ____/____/____
  - Last Day of Coverage ____/____/____
- ☐ Other ______________________

SECTION 3

SELECT COVERAGE(S): Dependents cannot be enrolled for coverage refused by the employee.
- ☐ **Medical** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)
- ☐ **Dental** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Vision** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Stand Alone Rx (no medical coverage)** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Long Term Disability** (if applicable choose option)
- ☐ **Short Term Disability** (if applicable choose option)

SELECT COVERAGE OPTIONS: Choose only one option for each coverage.
- **Medical** ☐ Indemnity ☐ PPO
- **Dental** ☐ Indemnity ☐ PPO ☐ Buy-Up ☐ Pre-Paid *
  - * Complete Pre-Paid Office # in Section 6
- **LTD** ☐ Buy-Up
  - ☐ Flex AbilityGuard $____ (up to 50% of salary)
- **STD** ☐ Buy-Up
  - ☐ Flex AbilityGuard $____ (up to 50% of salary)

SECTION 4

REFUSE/DROP COVERAGE(S):
- ☐ **Medical** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)
- ☐ **Dental** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Vision** ☐ Employee ☐ Spouse ☐ Child(ren)
- ☐ **Long Term Disability** ☐ **Short Term Disability**

I have been offered the above coverages and wish to refuse/drop enrollment for the following reasons:
- ☐ Covered under another insurance plan
- ☐ Other ______________________ (additional information may be required)

SECTION 5

LOSS OF OTHER COVERAGE:

I and/or my dependents were previously covered under another group plan. Loss of coverage was due to:

Termination of Employment	____/____/____
Divorce	____/____/____
Death of Spouse	____/____/____
Term./Expiration of Coverage	____/____/____

SECTION 6

	Add	Drop	Last	First	MI	Sex	Birth Date (MM DD YYYY)	Social Security Number	Pre-Paid Office # (See directory)
Employee Name	☐	☐				M F	- -	- -	

Street address | City | State ZIP

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Home Phone: ( ) -

Are you: ☐ Actively at work ☐ Retired ☐ Other ________ (additional information may be required) Occupation/Job Title:

Number of hours worked per week: Annual Salary (nearest dollar): , , Date of Full Time Hire (MM DD YYYY): - -

	Add	Drop	Last	First	MI	Sex	Student	Birth Date (MM DD YYYY)	Social Security Number	Pre-Paid Office # (See directory)
Spouse Name	☐	☐				M F		- -	- -	
Child Name	☐	☐				M F	Y N	- -	- -	
Child Name	☐	☐				M F	Y N	- -	- -	
Child Name	☐	☐				M F	Y N	- -	- -	
Child Name	☐	☐				M F	Y N	- -	- -	

A) Have you included stepchildren? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No

B) Is this your first eligible child? ☐ Yes ☐ No If "no," please list all eligible children above.

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

"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."

Signature: ______________________ Date (MM DD YYYY) - -