GUARDIAN®

• 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 (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 ☐ Add Spouse ☐ Add Children

☐ New Hire ☐ Marriage Date ____/____/____ ☐ Newborn

☐ Previously refused this coverage ☐ Previously refused this coverage ☐ Previously refused this coverage

☐ Loss of Other Coverage (Complete Section 5 if applicable) ☐ Loss of Other Coverage (Complete Section 5 if applicable) ☐ Adoption Date ____/____/____

☐ Loss of Other Coverage (Complete Section 5 if applicable)

SECTION 2

(The date of withdrawal cannot be prior to the date this form is completed and signed.)

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

☐ Termination of Employment * Last Day of Coverage ____/____/____

☐ Retirement *

*Last Day Worked ____/____/____

*Last Day of Coverage ____/____/____

☐ Other _____

SECTION 3

SELECT COVERAGE(S): Dependents cannot be enrolled for coverages refused by the employee.

☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)

☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)

☐ **Long Term Disability** (if applicable, choose one option below)
☐ Buy-Up ☐ Flex AbilityGuard $_____ up to 50% of salary

☐ **Short Term Disability** (if applicable, choose one option below)
☐ Buy-Up ☐ Flex AbilityGuard $_____ up to 50% of salary

SECTION 4

REFUSE/DROP COVERAGE(S): (See Refusal on back)

☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)

☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)

☐ **Long Term Disability**

☐ **Short Term Disability**

I have been offered the above coverages and wish to refuse/ drop enrollment for the followng 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

Employee Name — Add ☐ Drop ☐ Last | First | MI | Sex M F | Birth Date (MM DD YYYY) | Social Security Number

Street address | City | State | ZIP

Home Phone: ( ) - Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

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
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, 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. The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

Signature: _____ Date (MM DD YYYY) - -