GUARDIAN®

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

ENROLLMENT/CHANGE FORM LIFE/DENTAL/DISABILITY/VISION

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

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

☐ Drop Employee (Complete Section 4)
☐ Termination of Employment *
☐ Retirement *
*Last Day Worked _____/_____/_____
*Last Day of Coverage _____/_____/_____
☐ Other ____________________

☐ Drop Dependents (Complete Section 4)
Last Day of Coverage _____/_____/_____

SECTION 3

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

☐ **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** (if applicable choose option)
☐ **Short Term Disability** (if applicable choose option)

SELECT COVERAGE OPTIONS: Choose only one option for each coverage.

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):

☐ **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

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

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	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, 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) - -