

Group Insurance Enrollment/Change Form THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA Page 1 of 4

Guardian Life, P.O. Box 14319, Lexington, KY 40512

Please print clearly and mark carefully.

	Date of Birth (mm-dd-yyyy)				Phone: () -
Status (crieck all trial apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent	TIN	rop Gender Soci	Add Drop Gender		Address/City/State/Zip:
	Date of Birth (mm-dd-yyyy)				Phone: () -
	Social Security Number or TIN). Gender 	ncludes "Partner"	ears on this form, it also i	Spouse (wherever the term "Spouse" appears on this form, it also includes "Partner"). Address/City/State/Zip:
About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.	sh to enroll for coverage or whom you qualify fo Iditional information m	nts you wis ort; and fo lations. Ad	he depender nancial supp les and regul hew.	lude the names of the relies on you for five subject to IRS rull, a niece or a nep	About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person th you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standa dependents such as a grandchild, a niece or a nephew.
			Date of full time hire:		Work Status: □ Active □ Retired □ Cobra/State Continuation Hours worked per week:
				Title:	About Your Job: Job Title:
Date of marriage/union: Placement date of adopted child:		partner? 🔲 \ pendents? 🔲	Are you married or do you have a partner? □ Yes □ No Do you have children or other dependents? □ Yes □ No	Are you married or do you have a partner? ☐ Yes ☐ No Do you have children or other dependents? ☐ Yes ☐ No	
		*	🗆 W ork	ome	Email Address (indicate primary) 🗖 Home
					Phone (indicate primary): ☐ Home (_ ☐ W ork (☐ Mobile (
			d-yy):	Date of Birth (mm-dd-yy):	Gender: □ M □ F
State			City		Address
TIN must be provided if tTerm Disability ability Coverage.	Your Social Security Number of TIN must be provenrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	Yo Co			
expayer Identification	Social Security Number or Taxpayer Iden Number (TIN)		Employer Provided Identification:	Employer P	About You: First, MI, Last Name:
(Please obtain this from your Employer)		Subtotal Code:	Sub	Division:	Class:
Benefits Effective:	Group Plan Number: 00395732 ee Dependents	up Plan Numb spendents		CENTRAL SCHOOL DI	Employer Name: WEST SENECA CENTRAL SCHOOL DISTRICT PLEASE CHECK APPROPRIATE BOX Initial Enrollment Add Employ

Child/Dependent 2: Address/City/State/Zip: Phone: () -	Add Drop Gender Social Security Number or Status (check all that apply) TIN
Child/Dependent 3:	
Address/City/State/Zip: Phone: () -	Date of Birth (mm-dd-yyyy)
Child/Dependent 4:	□ Add □ Drop Gender Social Security Number or Status (check all that apply) □ M □ F TIN □ Student (post high school) □ Disabled
Address/City/State/Zip: Phone: () -	Date of Birth (mm-dd-yyyy)
Drop Coverage: ☐ Drop Employee ☐ Drop Dependents The data of withdrawel corpor be prior to the data this form is	Coverage Being Dropped: ☐ Dental ☐ Employee ☐ Spouse ☐ Child(ren)
The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage:	
Loss Of Other Coverage: Land/or my dependents were previously covered under Loss of coverage was due to:	I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: Covered under another insurance plan Other
□ Divorce/Separation □ Death of Spouse □ Termination/Expiration of Coverage Coverage Lost □ Dental	(additional information may be required)
Dental Coverage: You must be enrolled to cover your dependents. Check only one box.	ndents. Check only one box.
Employee Only Employee & SpouseEmployee & Dependent/(Employee & Employee, Spouse & Dependent/Child(ren) Dependent/Child(ren)

Signature

☐ I do not want Dental Coverage because (Check all that apply):

□ I am covered under another Dental plan□ My spouse is covered under another Dental plan□ My dependents are covered under another Dental plan

- I understand that my dependents cannot be enrolled for a coverage if I am not enrolled for that coverage.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.
- I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- understand that I must meet eligibility requirements for all coverages that I have chosen above

- agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above
- I agree that my employer or my employer's designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.
- this election only by providing (thirty) 30 days prior written notice By my signature below, I affirmatively consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change
- By my signature below, I affirmatively consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I state that the information provided above is true and correct to the best of my knowledge and belief

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements

The laws of New York require the following statement appear: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

	SIGNATURE OF EMPLOYEE	
ı	YEE X	
	DATE	

Enrollment Kit 00395732, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, misleading information is guilty of a felony of the third degree. 악

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

in state prison Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements

include imprisonment, fines or a denial of insurance benefit. Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may

Any person who knowingly or wilfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in on for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits subject to the conditions/provisions of the policy. also

penalties or dental of insurance benefits. Oregon: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements false information, or conceals for purpose of misleading information concerning any fact material thereto, may be committing a fraudule tatements of claim containing any materially a fraudulent act, and may be subject to civil

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

deceptive statement is guilty of insurance fraud. Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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.

Rhode Island: Any person who knowingly and wilfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.