GUARDIAN® The Guardian Life Insurance Company of America

Wholly Owned Subsidiaries:
(see paragraph "Pre-Paid Dental" on reverse side)
Managed Dental Care (MDC) (CA)
Managed DentalGuard (MDG) (TX, NJ)
First Commonwealth (FCW) (IL, MO, IN, WI) (For Plans in MI see (h) on reverse side)

- Please Print clearly in Black or Blue ink
- Please Print in Capital Letters only

ENROLLMENT/CHANGE FORM ALL COVERAGES

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 can only be enrolled in the same coverages as selected 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)
- ☐ **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 ☐ Buy-Up
- **Dental** ☐ Indemnity ☐ PPO ☐ Buy-Up ☐ DNO
  ☐ Pre-Paid (MDC; MDG; FCW) (PPD; DHMO)
  (You must select a primary care dental office for the Pre-Paid Dental option. Complete Pre-Paid Dental 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 and/or coverage.
- ☐ 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 Dental Office # (See directory)
Emp. Name	☐	☐				M F		- -	- -	

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 Dental 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. **C)** What is your primary language? **D)** Do you have a disability which would affect your ability to communicate or read? ☐ Yes ☐ No

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 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.

Signature: ______________________________ Date (MM DD YYYY) - -