

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)

<b>SECTION 1</b>	<input type="checkbox"/> Add Employee <input type="checkbox"/> New Hire <input type="checkbox"/> Previously refused this coverage <input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)	<input type="checkbox"/> Add Spouse Marriage Date ____/____/____ <input type="checkbox"/> Previously refused this coverage <input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)	<input type="checkbox"/> Add Children <input type="checkbox"/> Newborn <input type="checkbox"/> Previously refused this coverage <input type="checkbox"/> Adoption Date ____/____/____ <input type="checkbox"/> Loss of Other Coverage (Complete Section 5 if applicable)	<b>SECTION 2</b>	<input type="checkbox"/> Drop Employee (Complete Section 4) The date of withdrawal cannot be prior to the date this form is completed and signed. <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement Last Day Worked ____/____/____ Last Day of Coverage ____/____/____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Drop Dependents (Complete Section 4)
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<b>SECTION 3</b>	<b>SELECT COVERAGE(S):</b> Dependents can only be enrolled in the same coverages as selected by the employee. <input type="checkbox"/> Medical <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Life <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> AD&D <input type="checkbox"/> Employee <input type="checkbox"/> Family (includes EE, Sp, Ch) <input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Vision <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Long Term Disability (if applicable choose option) <input type="checkbox"/> Short Term Disability (if applicable choose option)	<b>SELECT COVERAGE OPTIONS:</b> Choose only one option for each coverage. <b>Medical</b> <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> Buy-Up <b>Dental</b> <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> Buy-Up <input type="checkbox"/> DNO <input type="checkbox"/> 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) <b>LTD</b> <input type="checkbox"/> Buy-Up <input type="checkbox"/> Flex AbilityGuard \$ ____ (up to 50% of salary) <b>STD</b> <input type="checkbox"/> Buy-Up <input type="checkbox"/> Flex AbilityGuard \$ ____ (up to 50% of salary)	<b>SECTION 4</b>	<b>REFUSE/DROP COVERAGE(S):</b> <input type="checkbox"/> Medical <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Life <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> AD&D <input type="checkbox"/> Employee <input type="checkbox"/> Family (includes EE, Sp, Ch) <input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Vision <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Short Term Disability I have been offered the above coverages and wish to refuse/drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan and/or coverage. <input type="checkbox"/> Other _____ (additional information may be required)	<b>SECTION 5</b>	<b>LOSS OF OTHER COVERAGE:</b> 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 ____/____/____
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<b>SECTION 6</b>	Add Drop Last First MI Sex Birth Date (MM DD YYYY) Social Security Number Pre-Paid Dental Office # (See directory) Emp. Name <input type="checkbox"/> <input type="checkbox"/> _____ - - - - - M F _____ - - - - - Street address _____ City _____ State ZIP _____ Home Phone: ( ) - - - - - Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed Are you: <input type="checkbox"/> Actively at work <input type="checkbox"/> Retired <input type="checkbox"/> 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): _____
<b>SECTION 6</b>	Add Drop Last First MI Sex Student Birth Date (MM DD YYYY) Social Security Number Pre-Paid Dental Office # (See directory) Spouse Name <input type="checkbox"/> <input type="checkbox"/> _____ - - - - - M F _____ - - - - - Child Name <input type="checkbox"/> <input type="checkbox"/> _____ - - - - - M F Y N - - - - - Child Name <input type="checkbox"/> <input type="checkbox"/> _____ - - - - - M F Y N - - - - - Child Name <input type="checkbox"/> <input type="checkbox"/> _____ - - - - - M F Y N - - - - - Child Name <input type="checkbox"/> <input type="checkbox"/> _____ - - - - - 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) \_\_\_\_\_

The following applies to health benefit plans unless a state law provides otherwise. For plans that are subject to small group reform, Guardian may require a health statement for Major Medical coverage for the purpose of rating the group and for use in states in which we participate in the reinsurance pool.

#### **IMPORTANT NOTICE REGARDING YOUR MEDICAL COVERAGE**

**SPECIAL ENROLLMENT RIGHTS:** If you are refusing enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan as a new entrant, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents as new entrants, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. You may also enroll as a late enrollee at any time other than for those situations explained above.

**PREEXISTING CONDITION LIMITATION:** This group health benefit plan contains a preexisting condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees). The preexisting condition limitation relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 month period prior to an individual's enrollment date. The exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the preexisting condition limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any preexisting condition limitation will apply to you, you must present your certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health benefit plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health benefit plan, or a health benefit plan issued under the Peace Corps Act.

You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO). If necessary, this plan and Guardian will assist you in obtaining a certificate from any of these entities.

This Preexisting Condition Limitation notice is being issued to you pursuant to the Federal Health Insurance Portability and Accountability Act of 1996 and reflects the protection afforded under federal law. If the state law applicable to a fully insured Guardian plan is more beneficial to covered individuals as to the length of the preexisting condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Guardian plan.

If the plan requires contributions, and I have refused life or disability insurance, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and Guardian reserves the right to reject my request.

Proof of insurability does not apply to dental, but I will be considered a late entrant and my dental benefits will be limited for specific periods of time. However, I and/or my dependents will not be subject to late entrant penalties if dental coverage under another plan is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or where a court has ordered coverage be provided for an eligible spouse or eligible minor child(ren), and application for this plan and documentation of the loss of other coverage is received within 31 days of the termination of such coverage. Neither proof of insurability nor the late entrant provision apply to Pre-Paid dental benefits.

**Pre-Paid Dental:** The Pre-Paid Dental plan refers to, as applicable, (a) Managed DentalGuard dental HMO plans underwritten by Managed Dental Care (in CA) or Managed DentalGuard, Inc. (in TX); or (b) Managed DentalGuard plans underwritten by Managed DentalGuard, Inc. (in NJ); or (c) Managed DentalGuard plans underwritten by The Guardian Life Insurance Company of America (in FL or in NY); or (d) First Commonwealth Insurance Company (in IL); or (e) First Commonwealth of Missouri, Inc. (in MO); or (f) First Commonwealth Limited Health Services Corporation (in IN); or (g) First Commonwealth Limited Health Service Corporation (in WI); or (h) In Michigan, First Commonwealth Limited Health Services Corporation of Michigan. Eligibility for this coverage is only available at the open enrollment period.

**Agreement:** I hereby (1) request coverage for the Group Insurance and/or coverage for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for coverage, or agree that the contributions be added to my dues; (3) state that I became an employee, and do currently work the number of hours per week stated on this form; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. I understand that, in order to be accepted for coverage, my signed and completed application for coverage must be received by Guardian within 31 days of my eligibility for coverage. I authorize any provider, insurer, or other organization to release the necessary information regarding my dental history, treatment or benefits to Guardian or its subsidiary or authorized agent, for the purpose of plan administration.