



THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Group Insurance Enrollment/Change Form

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

Please print clearly and mark carefully.

Employer/Planholder Name: <b>WEST SENECA CENTRAL SCHOOL DISTRICT</b>	Group Plan Number: <b>00395732</b>	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Employee/Member Dependents/Family Members <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		
<p>In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term, and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.</p>		

Class: \_\_\_\_\_ Division: \_\_\_\_\_ Subtotal Code: \_\_\_\_\_ (Please obtain this from your Employer/Planholder)

<b>About You:</b> Full Legal Name-First, MI, Last Name:  What is the name you go by? (optional)	Employer/Planholder Provided Identification:  _____	Social Security Number or Taxpayer Identification Number (TIN)  ____ - ____ - ____  Your Social Security Number or TIN must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	
Address	City	State	Zip
Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth (mm-dd-yy): ____ - ____ - ____	
Phone (indicate primary): <input type="checkbox"/> Home ( ____ ) ____ - ____ <input type="checkbox"/> Work ( ____ ) ____ - ____ <input type="checkbox"/> Mobile ( ____ ) ____ - ____			
E mail Address (indicate primary) <input type="checkbox"/> Home _____ <input type="checkbox"/> Work _____			
Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you married or in a civil union? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Placement date of adopted child: ____ - ____ - ____		Date of marriage/civil union: ____ - ____ - ____	

<b>About Your Job:</b>	Job Title: _____
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation Hours worked per week: _____	Date of full time hire: ____ - ____ - ____

**About Your Family:** Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Your dependent's Social Security Number or TIN must be provided if enrolling for Life Coverage. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse  Address/City/State/Zip:  Phone: ( ) -	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number or TIN  ____ - ____ - ____  Date of Birth (mm-dd-yyyy)  ____ - ____ - ____	
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Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number or TIN ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number or TIN ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number or TIN ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number or TIN ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

<p><b>Drop Coverage:</b></p> <input type="checkbox"/> Drop Employee/Member <input type="checkbox"/> Drop Dependents/Family Members The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: ____ - ____ - ____ <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement Last Day Worked: ____ - ____ - ____ <input type="checkbox"/> Other Event: _____ Date of Event: ____ - ____ - ____	<p><b>Coverage Being Dropped:</b></p> <input type="checkbox"/> Dental <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Basic Term Life <input type="checkbox"/> Voluntary Term Life
<p><b>Loss Of Other Coverage:</b></p> I and/or my dependents were previously covered under Loss of coverage was due to: <input type="checkbox"/> Termination of Employment: ____ - ____ - ____ <input type="checkbox"/> Divorce/Separation ____ - ____ - ____ <input type="checkbox"/> Death of Spouse ____ - ____ - ____ <input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____ Coverage Lost <input type="checkbox"/> Dental	<p>I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:</p> <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____ (additional information may be required)

**Dental Coverage:** You must be enrolled to cover your dependents/family members. Check only one box.

PPO	<input type="checkbox"/>	Employee/Member Only <input type="checkbox"/>	Employee/Member & Spouse <input type="checkbox"/>	Employee/Member & Dependent/Child(ren) <input type="checkbox"/>	Employee/Member, Spouse & Dependent/Child(ren) <input type="checkbox"/>
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I do not want Dental Coverage because (Check as applicable):

- I am covered under another Dental plan
- My spouse is covered under another Dental plan
- My dependents/family members are covered under another Dental plan

**Signature**

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I agree that my employer/planholder or my employer/planholder'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.
- 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 page.

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/MEMBER X \_\_\_\_\_

DATE \_\_\_\_\_

**Fraud Warning Statements**

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

**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 insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**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 a 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, or misleading information is guilty of a felony of the third degree.

**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.

**Louisiana and Texas:** 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 in state prison.