



The Guardian Life Insurance Company of America

Form No. GG-011365
Change in Enrollment Status

Northeast Regional Office PO Box 26040 Lehigh Valley PA 18002-6040
Midwest Regional Office PO Box 8012 Appleton WI 54913-8012
Western Regional Office PO Box 2454 Spokane WA 99210-2454
Norwell Regional Office PO Box 9121 Norwell MA 02061-9121

Before completing this application, please read the IMPORTANT notice on the reverse side of this form concerning special enrollment rights and preexisting condition limitations.

Complete this form if you are currently insured under a Guardian Group Plan and you wish to: add coverage for dependents acquired within the past 30 days. delete coverage for your dependents who are currently insured. enroll for or waive new benefits being added to the insurance plan. transfer to or from alternative medical (HMO) and/or Pre-Paid Dental coverage. waive existing benefits or withdraw completely from coverage under this plan.

COMPLETE THE APPROPRIATE SECTION, SIGN AND DATE WHERE INDICATED AT THE BOTTOM OF THE FORM.

PLANHOLDER NAME GROUP PLAN #
EMPLOYEE NAME (LAST, FIRST, MI) CERT # BIRTH DATE SOC. SEC. #

CHANGE IN DEPENDENT STATUS (Complete ONLY to request the addition or deletion of dependents.)

I am applying for coverage for my dependents listed below; (If spouse, include date of marriage with relationship. Complete enrollment section for dependent coverage.)

Table with 6 columns: NAME (LAST, FIRST, MIDDLE INITIAL), SEX, RELATIONSHIP, SOC. SEC. NO., BIRTH DATE, STUDENT. Includes checkboxes for M/F and Y/N.

Are any dependent child(ren) adopted? Yes No If "yes," indicate name and date of adoption:

Have you included stepchildren as dependents? Yes No If "yes," indicate name/s:

Do your stepchildren reside with you? Yes No Are they dependent upon you for support and maintenance? Yes No

The following of my dependents are no longer eligible for coverage and should be deleted from the plan:

Table with 4 columns: NAME (LAST, FIRST, MIDDLE INITIAL), SEX, RELATIONSHIP, REASON AND DATE OF TERMINATION. Includes checkboxes for M/F.

ALTERNATIVE MEDICAL/DENTAL COVERAGE (Complete ONLY if transferring between plans.)

I wish to transfer coverage for Myself Myself and dependents from:

- MEDICAL (HMO) coverage with to the Guardian Major Medical Plan.
MAJOR MEDICAL DEDUCTIBLE AMOUNT \$ (Where available, the deductible option applies to the Employee and covered Dependents.)
PRE-PAID DENTAL coverage with to the Guardian Dental Plan.

Because (please check):

- I moved out of the area serviced by the Medical (HMO) organization. I moved out of the area serviced by the Pre-Paid Dental Plan.
It is the open enrollment period. Transfer date is
It is not the open enrollment period, but wish to transfer effective (Completed health statement must be submitted with this request.)

I wish to transfer coverage for Myself Myself and dependents from:

- MEDICAL coverage with Guardian to coverage with Medical (HMO)
DENTAL coverage with Guardian to coverage with Pre-Paid Dental Plan.

Because (please check):

- I now live in the area serviced by the Medical (HMO) organization Pre-Paid Dental Plan
It is the open enrollment period. Transfer date is

ENROLLMENT FOR NEW BENEFITS/NEW DEPENDENTS ADDED TO THE INSURANCE PLAN (Complete ONLY for enrollment for new benefits for employees and dependents already insured or new dependents being added to the plan.)

EMPLOYEE COVERAGE REQUESTED:

- Life/Accidental Death & Dismemberment Life (w/o AD & D)
Optional Life Amount \$
Major Medical only (w/o Rx card) Major Medical/Rx card
Major Medical deductible amount \$ \*
PPO/Major Medical
Rx card only (w/o Major Medical) Dental Vision
Short Term Disability Long Term Disability

DEPENDENT COVERAGE REQUESTED (available only to dependents of insured employees):

- Dependent Life Optional Life Amount \$
Major Medical only (w/o Rx card) Major Medical/Rx card
Rx card only (w/o Major Medical) Dental Vision
PPO/Major Medical (must be same as employee election)

I ELECT DEPENDENT COVERAGE FOR:

- spouse only spouse & child(ren) child(ren) only
Dependents to be included in my HMO Pre-Paid Dental alternative coverage.

(Where available, the deductible option applies to the Employee and covered Dependents.)

If you must contribute to the cost of the plan and are not applying for all available coverages at this time, please read and sign the Refusal Of Coverage section of this form.

BENEFICIARY DESIGNATION (Complete ONLY if enrolling for Life Insurance. Include full proper name and relationship; i.e.: Mary A. Jones, wife.)

Table with 2 columns: NAME, RELATIONSHIP

WITHDRAWAL/REFUSAL OF COVERAGE (Complete ONLY [a] to waive new benefits being added; OR [b] to withdraw from benefits already inforce; OR [c] to withdraw totally from insurance plan.)

I hereby give notice of withdrawal from participation in this plan for spouse only spouse & child(ren) child(ren) only myself and dependents effective This shall also be the date that I withdraw my payroll deduction authorization, if any. Should I elect to participate again in this plan, I must furnish evidence of insurability satisfactory to Guardian for myself and my dependents at my own expense. Proof of insurability does not apply to major medical, dental or vision coverage.

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

-OR-

If the plan requires contributions, and I have refused the 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 major medical, dental or vision coverages. However, late entrant penalties may apply to major medical and dental and enrollment delays may apply to vision. Refer to Special Enrollment Rights on the reverse for additional information.

I decline the following employee coverage/s available to me:

- All Coverage Life/Accidental Death & Dismemberment
Life (w/o AD&D) Optional Life Major Medical only (w/o Rx Card) PPO/Major Medical
Major Medical/Rx Card Rx Card only (w/o Major Medical) Dental Vision Short Term Dis. Long Term Dis.

because: I am insured under another policy or group plan (please indicate information below) Other reasons

Policy or Plan No. Carrier Name

I decline the following coverage/s available to my dependents:

- All Coverage Dependent Life Optional Life
Major Medical only (w/o Rx Card) Major Medical/Rx Card Rx Card only (w/o Major Medical) PPO/Major Medical Dental Vision

because: My dependents are insured under another policy or group plan (please indicate information below) Other reasons

Policy or Plan No. Carrier Name

Table with 3 columns: SIGNATURE OF EMPLOYEE, SIGNATURE OF WITNESS, DATE

## IMPORTANT NOTICE

*Unless state law provides otherwise, the following apply to health plans issued or renewed on or after July 1, 1997.*

### **SPECIAL ENROLLMENT RIGHTS**

If you are declining 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, 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, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

### **PREEXISTING CONDITION LIMITATION:**

This group health 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 months period prior to an individual's enrollment date. This 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 certificate or certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health 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 plan, or a health 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.**