



THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Group Insurance Enrollment/Change Form

GUARDIAN®

Northeast Regional Office, P.O. Box 26040,  
Lehigh Valley, PA 18002-6040

Please print clearly and mark carefully.

Employer Name: <b>Town of North Elba</b>	Group Plan Number: <b>00408897</b>	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX	Initial Enrollment	Add Employee/Dependents
	Drop/Refuse Coverage	Information Change

Class: Class 1      Division: \_\_\_\_\_      Subtotal Code: \_\_\_\_\_      **(Please obtain this from your Employer)**

<b>About You:</b>		Social Security Number	
First, MI, Last Name: _____			
Address		City	State
Gender: M F		Date of Birth (mm-dd-yy): _____	Phone: (    ) _____
Email Address:		Are you married or do you have a spouse? Yes No Date of marriage/union: _____	
		Do you have children or other dependents? Yes No Placement date of adopted child: _____	

<b>About Your Job:</b>	Hours worked per week: _____	Job Title: _____
Work Status:	Date of full time hire: _____	
Active      Retired      Cobra/State Continuation		

**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.**

Spouse (First, MI, Last Name)	Gender	Date of Birth (mm-dd-yyyy)	
Child/Dependent 1:	Gender	Date of Birth (mm-dd-yyyy)	Status (check all that apply) Student (post high school)      Disabled Non standard dependent
Child/Dependent 2:	Gender	Date of Birth (mm-dd-yyyy)	Status (check all that apply) Student (post high school)      Disabled Non standard dependent
Child/Dependent 3:	Gender	Date of Birth (mm-dd-yyyy)	Status (check all that apply) Student (post high school)      Disabled Non standard dependent
Child/Dependent 4:	Gender	Date of Birth (mm-dd-yyyy)	Status (check all that apply) Student (post high school)      Disabled Non standard dependent

<p><b>Drop Coverage:</b></p> <p>Drop Employee      Drop Dependents</p> <p>The date of withdrawal cannot be prior to the date this form is completed and signed.</p> <p>Last Day of Coverage: _____</p> <p>Termination of Employment      Retirement</p> <p>Last Day Worked: _____</p> <p>Other Event: _____</p> <p>Date of Event: _____</p>	<p><b>Coverage Being Dropped:</b></p> <table border="0"> <tr> <td>Dental</td> <td>Employee</td> <td>Spouse</td> <td>Child(ren)</td> </tr> <tr> <td>Vision</td> <td>Employee</td> <td>Spouse</td> <td>Child(ren)</td> </tr> </table>	Dental	Employee	Spouse	Child(ren)	Vision	Employee	Spouse	Child(ren)
Dental	Employee	Spouse	Child(ren)						
Vision	Employee	Spouse	Child(ren)						
<p><b>Loss Of Other Coverage:</b></p> <p>I and/or my dependents were previously covered under another group plan. Loss of coverage was due to:</p> <p>Termination of Employment: _____</p> <p>Divorce _____</p> <p>Death of Spouse _____</p> <p>Termination/Expiration of Coverage _____</p> <p><b>Coverage Lost</b>      Dental      Vision</p>	<p>I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:</p> <p>Covered under another insurance plan</p> <p>Other _____</p> <p>(additional information may be required)</p>								

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

Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse, & Dependent/Child(ren)
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PPO

I do not want this coverage. If you do not want this Coverage, please mark 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

**Vision Coverage: You must be enrolled to cover your dependents. Check only one box.**

Your Bi-weekly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse, & Dependent/Child(ren)
Full Feature - Designer	\$2.64	\$4.44	\$4.53	\$7.16

I do not want this coverage. If you do not want this Coverage, please mark all that apply:

I am covered under another Vision plan

My spouse is covered under another Vision plan

My dependents are covered under another Vision plan

**Signature**

An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.

I understand that the premium amounts shown above are estimations and are for illustrative purposes only.

You must be legally working in the United States, its possessions or the countries of Canada and Mexico in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations. You must be legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.

Your coverage will not be effective until approved by a Guardian 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.

I agree that my employer may deduct premiums from my pay or add premiums to my dues, if they are required for the coverage I have chosen above.

**I state that the information provided above is true and correct to the best of my knowledge.**

Any person who 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 hereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil Penalties, or denial of insurance benefits (Does not apply to Life Insurance).

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

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 has the right to reject your request.

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 of 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 X \_\_\_\_\_

DATE \_\_\_\_\_

Enrollment Kit 00408897\_0001\_EN

### Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form, as a substitute for fraud warnings that appear in other areas of the claim form:

**Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to criminal and civil penalties.

**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.

**Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**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 knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or 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 confinement in state prison.

**Maine, Tennessee, Virginia 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.

**Maryland and Rhode Island:** Any person who knowingly and willfully 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.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment or 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 or denial of insurance benefits.

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

**Pennsylvania:** Any person who knowingly and with the 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.