

## Group Insurance Enrollment/Change Form THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA Page 1 of 4

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

Please print clearly and mark carefully.

		Date of Diffit (IIIIII-da-yyyy)		Phone: ( ) -
		Date of Rirth (mm-dd-2000)		
		□ M □ F		Address/City/State/Zip:
		ler Social Security Number or ity:	Gender Identity:	Spouse
onal space is needed, ndent's Social Security paper and keep a copy ild, a niece or a	. If additional sp 'our dependent's d-yy) the paper a a grandchild, a ni	Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, irate sheet of paper with this information along with your enrollment form. Your dependent's Social Securit be provided if enrolling for Life Coverage. Be sure to sign and date (mm-dd-yy) the paper and keep a copiditional information may be required for non-standard dependents such as a grandchild, a niece or a	of the dependents you is information along w or Life Coverage. Be su e required for non-star	About Your Family: Please include the names of the dependents you wish to enroll for coverage. If additing please attach a separate sheet of paper with this information along with your enrollment form. Your dependence or TIN must be provided if enrolling for Life Coverage. Be sure to sign and date (mm-dd-yy) the for your records. Additional information may be required for non-standard dependents such as a grandch nephew.
			Date of full time hire:	Work Status:  ☐ Active ☐ Retired ☐ COBRA/State Continuation ☐ 2  Hours worked per week:
				About Your Job: Job Title:
	ge/civil union:	☐ No Date of marriage/civil union ed child:	Are you married or in a civil union? ☐ Yes ☐ No☐ Yes ☐ No☐ Placement date of adopted child:	Are you marric Do you have children or other dependents? ☐ Yes ☐ No
				Email Address (indicate primary) 🗆 Home
				Phone (indicate primary): ☐ Home ()
			m-dd-yy):	Gender Identity: $\square$ M $\square$ F Date of Birth (mm-dd-yy):
Zip	State		City	Address
	N must be provided if Term Disability ility Coverage.	Your Social Security Number of TIN must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.		What is the name you go by? (optional)
	payer Identification )	Social Security Number or Taxpayer Identi Number (TIN)	Employer/Planholder Provided Identification:	About You:  Full Legal Name-First, MI, Last Name:
from your der)	(Please obtain this from Employer/Planholder)	e: 	Subtotal Code:	Class: Division:
o be times, when ilder selected, other pluder selected, other plupendents, or a similar members of your s any dispute	smbers. There will also be of plan your Planhol be of plan your Planhol elependents, eligible de ind to determine which jide), control if there is	referred to as Dependents/Family Me I your children. Depending on the typ of your family, as family members, d uide), to see how terms are defined a age, (sometimes called a member gu	lembers of your family will be I uish between your spouse and imilar term , and, to members sometimes called a member gu oup policy, certificate of cover.	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 pl 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.
☐ Information	☐ Drop/Refuse Coverage		☐ Add Employee/Member Dependents/Family Members	PLEASE CHECK APPROPRIATE BOX   Initial Enrollment Change
	Benefits Effective:_	Group Plan Number: 00579411	Group Plan N	Employer/Planholder Name: UTICA UNIVERSITY

CEF2022-NY

www.guardianlife.com

		plan	ner Dental	<ul> <li>□ I do not want Dental Coverage because (Check as applicable):</li> <li>□ I am covered under another Dental plan</li> <li>□ My spouse is covered under another Dental plan</li> <li>□ My dependents/family members are covered under another Dental plan</li> </ul>	□ I do not want De □ I am c □ My sp □ My de
			pouse n)	Employee/Member Employee/Member, Spouse Only & Dependent/Child(ren)  \[ \] \[ \] \[ \] \[ \] \[ \]	Option 1: Low Plan Option 2: High Plan
	heck only one box.	mily members. C	ndents/fa	ge: You must be enrolled to cover your dependents/family members. Check only one box.	Dental Coverage:
3d)	(additional information may be required)	(addition		□ Divorce/Separation □ Death of Spouse □ Termination/Expiration of Coverage Coverage Lost □ Dental	□ Divorce/Separation □ Death of Spouse □ Termination/Expira: Coverage Lost □ De
wish to drop enrollment for the following	I have been offered the above coverage(s) and wish to drop reasons:  Covered under another insurance plan Other	I have been offere reasons:  Covered under	rage	Loss Of Other Coverage: and/or my dependents were previously covered under Loss of coverage was due to:  Termination of Employment:	Loss Of Other Coverage: I and/or my dependents were pre was due to: Termination of Employment:
				overage:	Last Day of Coverage:  Termination of Employment Last Day W orked:  Other Event:
er 🔲 Spouse 🔲 Child(ren)	<b>1g Dropped:</b> □ Employee/Member 1 Life	Coverage Being Dropped:  Dental Em Basic Term Life Voluntary Term Life	ers	Drop Coverage: ☐ Drop Employee/Member ☐ Drop Dependents/Family Members The date of withdrawal cannot be prior to the date this form is completed and signed.	Drop Coverage:  □ Drop Employee/Member The date of withdrawal ca completed and signed.
	Date of Birth (mm-dd-yyyy)				Phone: ( ) -
☐ Non standard dependent				/Zip:	Address/City/State/Zip:
Status (check as applicable)	Social Security Number or	□ Drop Gender	☐ Add [		Child/Dependent 4:
	Date of Birth (mm-dd-yyyy)				Phone: ( ) -
Status (crieck as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent	TIN	Drop Identity:	☐ Add [	/Zip:	Address/City/State/Zip:
	Date of Birth (mm-dd-yyyyy)				Phone: ( ) -
Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent		□ Drop Gender Identity:	Add [	: /Zip:	Child/Dependent 2: Address/City/State/Zip:
					Phone: ( ) -
☐ Non standard dependent				/Zip:	Address/City/State/Zip:
Status (check as applicable)  Student (post high school)  Disabled	Social Security Number or TIN	☐ Add ☐ Drop Gender Identity:	D bpy		Child/Dependent 1:

## Signature

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage
- insurability. Guardian or its designee has the right to reject your request. 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
- 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 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 윽
- 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.)

GNATURE OF EMPLOYEE/MEMBER X	
	(T 000 ::0: Step ) (O I::0 :::0 :::0 :::0 ::)
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.

loss is guilty of a crime and may be subject to fines and confinement in state prison. 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

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

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 or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. information

confinements in state prison **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

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF 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.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.