Guardian

Group Insurance Enrollment/Change Form

# THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA



Plan Administrator: Chaim Cohen

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

Please print clearly and mark carefully.

| Employer Name: KULANU ACADEMY | Group Plan Number: 00516617 | Benefits Effective:_____ |
|---|---|---|

PLEASE CHECK APPROPRIATE BOX  Initial Enrollment  Re-Enrollment  Add Employee/Dependents  Drop/Refuse Coverage  Information Change
Increase Amount  Family Status Change

Class:_____ Division:_____ Subtotal Code:_____ (Please obtain this from your Employer)

## About You:

First, MI, Last Name:

Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

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: ____-____-_____

## About Your Job:

Hours worked per week: _____  Job Title:

Work Status:
Active  Retired  Cobra/State Continuation

Date of full time hire: _____ - _____ - _____

## About Your Family:

Please include the names of the dependents you wish to enroll for coverage. A dependent is a person who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent 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)<br>Address/City/State/Zip:<br>Phone: ( ) - | | Gender<br>M F | Social Security Number<br>_____ - _____ - _____<br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | |
| Child/Dependent 1:<br>Address/City/State/Zip:<br>Phone: ( ) - | Add Drop | Gender<br>M F | Social Security Number<br>_____ - _____ - _____<br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br>Student (post high school) Disabled<br>Non standard dependent |
| Child/Dependent 2:<br>Address/City/State/Zip:<br>Phone: ( ) - | Add Drop | Gender<br>M F | Social Security Number<br>_____ - _____ - _____<br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br>Student (post high school) Disabled<br>Non standard dependent |



DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

*DATE FORM PUBLISHED: Jul 12, 2020*

| | | | | |
|---|---|---|---|---|
| Child/Dependent 3:<br><br>Address/City/State/Zip:<br><br>Phone: ( ) - | Add Drop | Gender<br>M F | Social Security Number<br>_____ - _____ - _____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br>Student (post high school) Disabled<br>Non standard dependent |
| Child/Dependent 4:<br><br>Address/City/State/Zip:<br><br>Phone: ( ) - | Add Drop | Gender<br>M F | Social Security Number<br>_____ - _____ - _____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br>Student (post high school) Disabled<br>Non standard dependent |

## Drop Coverage:

Drop Employee Drop Dependents

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

Last Day of Coverage: _____-_____-_____

Termination of Employment Retirement

Last Day Worked: _____-_____-_____

Other Event: _____

Date of Event: _____-_____-_____

## Coverage Being Dropped:

Dental Employee Spouse Child(ren)

## Loss Of Other Coverage:

I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to:

Termination of Employment: _____-_____-_____

Divorce _____-_____-_____

Death of Spouse _____-_____-_____

Termination/Expiration of Coverage _____-_____-_____

Coverage Lost Dental

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

Covered under another insurance plan

Other _____

(additional information may be required)

## Dental Coverage:

You must be enrolled to cover your dependents. Check only one box.

| Your Semi-monthly Premium | Employee Only | EE & Spouse | EE & Dependent/Child(ren) | EE, Spouse & Dependent/Child(ren) |
|---|---|---|---|---|
| Option 1: Managed Dental Care | $11.68 | $23.37 | $30.61 | $40.08 |
| Option 2: PPO | $20.52 | $41.66 | $56.38 | $83.03 |

- If Managed Dental Care is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit guardianlife.com for a list of providers. If you do not select a PCD, one will be assigned for you.

Employee _____ Spouse _____ Child(ren) _____

I do not want this coverage. If you do not want this Dental 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

## Signature

I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

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

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

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.

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

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 if they are required for the coverage I have chosen above.

I agree that my [employer] or my employer'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.

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 purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil Penalties, or denial of insurance benefits (Does not apply to Life Insurance).

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.)

READ YOUR CERTIFICATE CAREFULLY,CERTAIN WAR RISKS ARE NOT ASSUMED.IN CASE OF ANY DOUBT,CONTACT YOUR COMPANY FOR FURTHER EXPLANATION.

The following section applies to these coverage(s): Accident Coverage, Specified Disease Coverage, Hospital Indemnity Coverage:

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

If you have questions about the benefits provided by this coverage, please contact us at 1-888-541-7846.

By my signature below, I affirmatively consent to receive electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I understand that I may change my election by providing Guardian 30 days prior written notice. I am opting out of receiving electronic copies of applicable insurance related documents and I understand such documents will be mailed to me at the address provided.

SIGNATURE OF EMPLOYEE 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.

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 subject to criminal and civil penalties.

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, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

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.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.



DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.

Maine, Tennessee 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 : 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.

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 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 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.

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.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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.