GUARDIAN® The Guardian Life Insurance Company of America

Wholly Owned Subsidiaries:
(see paragraph "Pre-Paid Dental" on reverse side)
Managed Dental Care (MDC) (CA)
Managed DentalGuard (MDG) (TX, NJ)
First Commonwealth (FCW) (IL, MO, IN, WI) (For Plans in MI see (h) on reverse side)

- Please Print clearly in Black or Blue ink
- Please Print in Capital Letters only

ENROLLMENT/CHANGE FORM ALL COVERAGES

Planholder Name (Company Name) | **Group Plan Number** | **Division** | **Class**

PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment/Refusal of Coverage (Complete Sections 1, 3, 4, 6) ☐ Add Employee/Dependents (Complete Sections 1, 3, 5, 6) ☐ Drop/Refuse Coverage (Complete Sections 2, 4, 6) ☐ Information Change (Complete Section 6)

SECTION 1

☐ Add Employee
- ☐ New Hire
- ☐ Previously refused this coverage
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Spouse
- ☐ Marriage Date ____/____/____
- ☐ Previously refused this coverage
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Add Children
- ☐ Newborn
- ☐ Previously refused this coverage
- ☐ Adoption Date ____/____/____
- ☐ Loss of Other Coverage (Complete Section 5 if applicable)

SECTION 2

☐ Drop Employee (Complete Section 4) ☐ Drop Dependents (Complete Section 4)
The date of withdrawal cannot be prior to the date this form is completed and signed.
☐ Termination of Employment
☐ Retirement
Last Day Worked ____/____/____ Last Day of Coverage ____/____/____
☐ Other _____

SECTION 3

SELECT COVERAGE(S): Dependents can only be enrolled in the same coverages as selected by the employee.

☐ **Medical** ☐ Employee ☐ Spouse ☐ Child(ren)
☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)
☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)
☐ **Dental** ☐ Employee ☐ Spouse ☐ Child(ren)
☐ **Vision** ☐ Employee ☐ Spouse ☐ Child(ren)
☐ **Long Term Disability** (if applicable choose option)
☐ **Short Term Disability** (if applicable choose option)

SELECT COVERAGE OPTIONS: Choose only one option for each coverage.

Medical ☐ Indemnity ☐ PPO ☐ Buy-Up
Dental ☐ Indemnity ☐ PPO ☐ Buy-Up ☐ DNO ☐ Pre-Paid (MDC; MDG; FCW) (PPD; DHMO)
(You must select a primary care dental office for the Pre-Paid Dental option. Complete Pre-Paid Dental Office # in Section 6)
LTD ☐ Buy-Up ☐ Flex AbilityGuard $____ (up to 50% of salary)
STD ☐ Buy-Up ☐ Flex AbilityGuard $____ (up to 50% of salary)

SECTION 4

REFUSE/DROP COVERAGE(S):
☐ **Medical** ☐ Employee ☐ Spouse ☐ Child(ren)
☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)
☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)
☐ **Dental** ☐ Employee ☐ Spouse ☐ Child(ren)
☐ **Vision** ☐ Employee ☐ Spouse ☐ Child(ren)
☐ **Long Term Disability** ☐ **Short Term Disability**
I have been offered the above coverages and wish to refuse/drop enrollment for the following reasons:
☐ Covered under another insurance plan and/or coverage.
☐ Other _____ (additional information may be required)

SECTION 5

LOSS OF OTHER COVERAGE:
I and/or my dependents were previously covered under another group plan. Loss of coverage was due to:
Termination of Employment ____/____/____
Divorce ____/____/____
Death of Spouse ____/____/____
Term./Expiration of Coverage ____/____/____

SECTION 6

Emp. Name — Add ☐ Drop ☐ | Last | First | MI | Sex M F | Birth Date (MM DD YYYY) | Social Security Number | Pre-Paid Dental Office # (See directory)

Street address | City | State | ZIP

Home Phone: ( ) -

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Are you: ☐ Actively at work ☐ Retired ☐ Other _____ (additional information may be required) Occupation/Job Title:

Number of hours worked per week: Annual Salary (nearest dollar): Date of Full Time Hire (MM DD YYYY):

Spouse Name — Add ☐ Drop ☐ | Last | First | MI | Sex M F | Student | Birth Date (MM DD YYYY) | Social Security Number | Pre-Paid Dental Office # (See directory)

Child Name — Add ☐ Drop ☐ | Last | First | MI | Sex M F | Student Y N | Birth Date (MM DD YYYY) | Social Security Number

Child Name — Add ☐ Drop ☐ | Last | First | MI | Sex M F | Student Y N | Birth Date (MM DD YYYY) | Social Security Number

Child Name — Add ☐ Drop ☐ | Last | First | MI | Sex M F | Student Y N | Birth Date (MM DD YYYY) | Social Security Number

Child Name — Add ☐ Drop ☐ | Last | First | MI | Sex M F | Student Y N | Birth Date (MM DD YYYY) | Social Security Number

A) Have you included stepchildren? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No **B)** Is this your first eligible child? ☐ Yes ☐ No If "no," please list all eligible children above. **C)** What is your primary language? **D)** Do you have a disability which would affect your ability to communicate or read? ☐ Yes ☐ No

Beneficiary Designation: (include full proper name and relationship) Name: Relationship:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer and/or HMO, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

Signature: _____ Date (MM DD YYYY) - -

The following applies to health benefit plans unless a state law provides otherwise. For plans that are subject to small group reform, Guardian may require a health statement for Medical coverage for the purpose of rating the group and for use in states in which we participate in the reinsurance pool.

IMPORTANT NOTICE REGARDING YOUR MEDICAL COVERAGE

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

SPECIAL ENROLLMENT RIGHTS: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your other coverage or your dependents other coverage), provided that you apply for 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. You may also enroll as a late enrollee at any time other than for those situations explained above.

PRE-EXISTING CONDITION LIMITATION: This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the Special Enrollment Rights, pre-existing condition exclusion and creditable coverage should be directed to our Member Services Department at PO Box 8008 Appleton WI 54912 or 1-800-873-4542.

This Pre-existing 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 pre-existing condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Guardian plan.

If the plan requires contributions, and I have refused life or disability 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 dental, but I will be considered a late entrant and my dental benefits will be limited for specific periods of time. However, I and/or my dependents will not be subject to late entrant penalties if dental coverage under another plan is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or where a court has ordered coverage be provided for an eligible spouse or eligible minor child(ren), and application for this plan and documentation of the loss of other coverage is received within 31 days of the termination of such coverage. Neither proof of insurability nor the late entrant provision apply to Pre-Paid dental benefits.

Pre-Paid Dental: The Pre-Paid Dental plan refers to, as applicable, (a) Managed DentalGuard dental HMO plans underwritten by Managed Dental Care (in CA) or Managed DentalGuard, Inc. (in TX); or (b) Managed DentalGuard plans underwritten by Managed DentalGuard, Inc. (in NJ); or (c) Managed DentalGuard plans underwritten by The Guardian Life Insurance Company of America (in FL or in NY); or (d) First Commonwealth Insurance Company (in IL); or (e) First Commonwealth of Missouri, Inc. (in MO); or (f) First Commonwealth Limited Health Services Corporation (in IN); or (g) First Commonwealth Limited Health Service Corporation (in WI); or (h) In Michigan, First Commonwealth Limited Health Services Corporation of Michigan. Eligibility for this coverage is only available at the open enrollment period.

Agreement: I hereby (1) request coverage for the Group Insurance and/or coverage for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for coverage, or agree that the contributions be added to my dues; (3) state that I became an employee, and do currently work the number of hours per week stated on this form; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. I understand that, in order to be accepted for coverage, my signed and completed application for coverage must be received by Guardian within 31 days of my eligibility for coverage. I authorize any provider, insurer, or other organization to release the necessary information regarding my dental history, treatment or benefits to Guardian or its subsidiary or authorized agent, for the purpose of plan administration.