



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

# Group Insurance Enrollment/Change Form

Page 1 of 8

Please print clearly and mark carefully.

Employer Name: <b>FXCM Global Services, LLC</b>	Group Plan Number: <b>00480798</b>	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input checked="" type="checkbox"/> Re-Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		
<input type="checkbox"/> Increase Amount <input type="checkbox"/> Family Status Change		

<b>About You:</b> First, MI, Last Name: <b>Iva Jurkovic</b>		Social Security Number <b>687546637</b>	
Address <b>20 Newport Parkway, Apt 601</b>		City <b>Jersey City</b>	State <b>NJ</b>
Zip <b>07310</b>		Gender: <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
Date of Birth (mm-dd-yy): <b>07-25-85</b>		Phone: ( <b>312</b> ) <b>9299137</b>	
Email Address: <b>iva.jurkovic@outlook</b>		Are you married or do you have a spouse? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have children or other dependents? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Date of marriage/union: <b>05-19-2017</b>	
Placement date of adopted child: _____			

<b>About Your Family:</b> 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. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.			
Spouse (First, MI, Last Name) <b>Juan Cafe</b>		Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Social Security Number <b>593 - 95 - 1922</b>
Address/City/State/Zip:		Date of Birth (mm-dd-yyyy)	
Phone: ( ) -			
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number - - - - -
Address/City/State/Zip:		Date of Birth (mm-dd-yyyy)	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Phone: ( ) -			
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number - - - - -
Address/City/State/Zip:		Date of Birth (mm-dd-yyyy)	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Phone: ( ) -			

CEF2014-NY

Questions? Call the Guardian Helpline (888) 600-1600

[www.guardianlife.com](http://www.guardianlife.com)

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DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Nov 12, 2015



**LIFE INSURANCE** *continued*

**Name your beneficiaries:** (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life,

[REDACTED]

[REDACTED]

[REDACTED] [REDACTED]

[REDACTED] [REDACTED]

[REDACTED] | [REDACTED]

[REDACTED] [REDACTED]

[REDACTED] [REDACTED]

[REDACTED] | [REDACTED]

[REDACTED] [REDACTED]

[REDACTED] [REDACTED]

[REDACTED] | [REDACTED]

[REDACTED]

[REDACTED]	
[REDACTED]	
[REDACTED]	
[REDACTED]	
[REDACTED]	
[REDACTED]	
[REDACTED]	

**Specified Disease Coverage:** You must be enrolled to cover your dependents

YOU MUST HAVE AT LEAST MAJOR MEDICAL INSURANCE OR AT LEAST BASIC HOSPITAL INSURANCE AND BASIC MEDICAL INSURANCE ON THE DATE OF THIS APPLICATION FOR SPECIFIED DISEASE COVERAGE. YOUR SIGNATURE AT THE END OF THIS FORM STATES THAT SUCH COVERAGE IS INFORCE ON SUCH DATE.

***Benefit reductions apply. Please see plan administrator.***

Employee Insurance Amount: ☐ \$5,000 ☐ \$10,000 ☐ \$15,000 ☒ \$20,000 ☐ \$25,000  
☐ I do not want this coverage.

**Spouse Insurance Amount:** ☒ 50% of the employee's amount  
☐ I do not want this coverage.

Dependent/Child(ren) ☐ 50% of the employee's amount  
☒ I do not want this coverage.

Do you have on the date of this application, at least major medical insurance or at least basic hospital insurance and basic medical insurance (required underlying coverage) in force for yourself and any dependents being enrolled? Employee ☒ Yes. ☐ No. Spouse ☐ Yes. ☐ No.

If yes, proceed to the next section. If you do not have such coverage, a certificate will not be issued.

Do you have on the date of this application, other specified disease coverage in force (or pending applications) for the same disease(s) for which you are applying for coverage herein for yourself and any dependents being enrolled? ☒ Yes. ☐ No.

Please indicate the number of specified diseases for which you have coverage in force (or pending applications) for yourself and any dependents being enrolled.  
Employee: 1 Dependents:



**If you or your dependent spouse elect Specified Disease, you must answer the following health questions.**

1. Has any proposed insured been diagnosed with or treated by a medical professional for any of the following conditions: cancer, carcinoma in situ, malignant melanoma, tumor (benign or malignant), Barrett's esophagus, Crohn's disease, ulcerative colitis, blood disorder (other than AIDS or HIV), any chronic or progressive disease of kidneys, liver (including hepatitis), lungs, including emphysema and COPD, pancreas or bone marrow? Or, been advised to have an organ transplant, including bone marrow or stem cell transplant?

Employee ☐ Yes ☒ No Spouse ☐ Yes ☐ No

2. Has any proposed insured been diagnosed with or treated by a medical professional for heart attack, heart disease or coronary artery disease, stroke or transient ischemic attack (TIA), or been advised to have bypass surgery, stent insertions or treatment for coronary arteries?

Employee ☐ Yes ☒ No Spouse ☐ Yes ☐ No

3. Has any proposed insured been diagnosed with or treated by a medical professional for uncontrolled blood pressure (requiring a change in medication or dosage in the past 6 months) or been diagnosed with or treated for diabetes (except if present only in pregnancy)?

Employee ☐ Yes ☒ No Spouse ☐ Yes ☐ No

4. Has any proposed insured been diagnosed with or treated by a medical professional for AIDS (acquired immune deficiency syndrome) or AIDS-Related Complex?

Employee ☐ Yes ☒ No Spouse ☐ Yes ☐ No

**IMPORTANT NOTES:**

- Based on your plan benefits and age, you may be required to complete an additional evidence of insurability form for Specified Disease.
- No later than 30 days following delivery of specified disease coverage, Guardian will ask in a written request whether at least major medical insurance or at least basic hospital insurance and basic medical insurance (required underlying coverage) is in force on the effective date of the specified disease coverage. If Guardian receives a written response that the required underlying coverage is not in force for an insured person on the effective date of the specified disease coverage, the specified disease coverage for that insured person will be voided from its beginning with a full premium refund for such person.

**Accident Coverage** You must be enrolled to cover your dependents.

**YOU MUST HAVE AT LEAST COMPREHENSIVE HOSPITAL, SURGICAL AND MEDICAL INSURANCE ON THE DATE OF THIS APPLICATION FOR ACCIDENT COVERAGE. YOUR SIGNATURE AT THE END OF THIS FORM STATES THAT SUCH COVERAGE IS IN FORCE ON SUCH DATE.**

Do you have on the date of this application, at least comprehensive hospital, surgical and medical insurance (required underlying coverage) in force for yourself and any dependents being enrolled? ☒ Yes ☐ No

If yes, proceed to the next section. If you do not have such coverage, a certificate will not be issued.

Your Semi-monthly premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: Value Plan	<input checked="" type="checkbox"/> \$6.24	<input type="checkbox"/> \$10.25	<input type="checkbox"/> \$10.49	<input type="checkbox"/> \$14.50
Option 2: Advantage Plan	<input type="checkbox"/> \$8.56	<input type="checkbox"/> \$13.98	<input type="checkbox"/> \$14.11	<input type="checkbox"/> \$19.52
Option 3: Premier Plan	<input type="checkbox"/> \$10.92	<input type="checkbox"/> \$17.79	<input type="checkbox"/> \$17.60	<input type="checkbox"/> \$24.47

☐ I do not want this coverage.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]

[REDACTED]

[REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]

[REDACTED]



- I acknowledge and consent to receiving electronic copies of insurance related documents, in lieu of paper copies, to the extent permitted by applicable law ☒ I voluntarily agree to that arrangement. ☐ I do not agree to that arrangement. I understand that I may change my election by providing Guardian 30 day prior written notice.
- I state that the information provided above is true and correct to the best of my knowledge.

I understand that this is a supplemental accident-only policy and that it does not provide coverage for and is not intended to replace comprehensive hospital, surgical and medical insurance. I understand that this policy does not provide coverage for sickness. I acknowledge that I have comprehensive hospital, surgical and medical insurance. If you have questions about the benefits provided by this coverage, please contact us at 1-800-541-7846.

**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).**

**Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. A discount is associated with the accelerated death benefits. A fee of up to \$250.00 will be required for the administrative cost of evaluating and processing Your application for this benefit.**

**The Policy permits the group Policyholder to change, reduce, restrict or terminate Your rights or benefits under the Policy without Your consent; and b) such change, reduction, restriction or termination may occur at a time when Your health status has changed and may affect Your ability to procure individual coverage. 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.)**

SIGNATURE OF EMPLOYEE X

*Ma Jurcanic*

DATE

*11/30/2018*

Enrollment Kit 00480798, 0001, EN

### 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.

**California:** For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

**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.

**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 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 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.