



The Guardian Life Insurance Company of America

Enrollment/Change Form

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

Please print clearly and mark carefully.

Employer Name: **SKYNET HEALTHCARE TECHNOLOGIES, INC**

Group Plan Number: **00520266**

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: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy): _____ - _____ - _____	Phone: () -	
Email Address:	Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage/union: _____ - _____ - _____	Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Placement date of adopted child: _____ - _____ - _____	

About Your Job:		Hours worked per week: _____	Job Title: _____
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra/State Continuation	Date of full time hire: _____ - _____ - _____	Annual Salary: \$ _____	

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 <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) _____ - _____ - _____	
Address/City/State/Zip:			
Phone: () -			
Child/Dependent 1: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F Social Security Number _____ - _____ - _____ 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
Child/Dependent 2: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F Social Security Number _____ - _____ - _____ 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

Child/Dependent 3: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> M <input type="checkbox"/> F	Gender Social Security Number ____ - ____ - ____ 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
Child/Dependent 4: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> M <input type="checkbox"/> F	Gender Social Security Number ____ - ____ - ____ 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

<p>Drop Coverage:</p> <p><input type="checkbox"/> Drop Employee <input type="checkbox"/> 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><input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement</p> <p>Last Day Worked: _____ - _____ - _____</p> <p><input type="checkbox"/> Other Event: _____ Date of Event: _____ - _____ - _____</p>	<p>Coverage Being Dropped:</p> <p><input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Vision <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Basic Life</p> <p><input type="checkbox"/> Long Term Disability</p>
<p>Loss Of Other Coverage:</p> <p>I and/or my dependents were previously covered under <u>another insurance plan</u>. Loss of coverage was due to:</p> <p><input type="checkbox"/> Termination of Employment: _____ - _____ - _____</p> <p><input type="checkbox"/> Divorce: _____ - _____ - _____</p> <p><input type="checkbox"/> Death of Spouse: _____ - _____ - _____</p> <p><input type="checkbox"/> Termination/Expiration of Coverage: _____ - _____ - _____</p> <p>Coverage Lost <input type="checkbox"/> Dental <input type="checkbox"/> Vision</p>	
<p>I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:</p> <p><input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____</p> <p style="text-align: center;">(additional information may be required)</p>	

Dental Coverage: You must be enrolled to cover your dependents. Check only one box.
<input type="checkbox"/> Employee Only <input type="checkbox"/> EE & Spouse <input type="checkbox"/> EE & Dependent/Child(ren) <input checked="" type="checkbox"/> EE, Spouse & Dependent/Child(ren)
PPO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>

Vision Coverage: You must be enrolled to cover your dependents. Check only one box.
<input type="checkbox"/> Employee Only <input type="checkbox"/> EE & Spouse <input type="checkbox"/> EE & Dependent/Child(ren) <input checked="" type="checkbox"/> EE, Spouse & Dependent/Child(ren)
Full Feature - Designer

Basic Life Coverage with Accidental Death and Dismemberment (AD&D):*Benefit reductions apply. Please see plan administrator.***Policy Amount**

Employee Only

 \$25,000

The Guarantee Issue

Amount is \$25,000.

Name your beneficiaries: (Primary beneficiary percentages must total 100%)**Primary Beneficiaries:**

Name: _____ Social Security Number: _____ % _____

Date of Birth (mm-dd-yy): _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

Name: _____ Social Security Number: _____ % _____

Date of Birth (mm-dd-yy): _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

Contingent Beneficiary: _____ Social Security Number: _____ % _____

Date of Birth (mm-dd-yy): _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy \$ _____

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Basic Life.

Long-Term Disability (LTD) Coverage:*Monthly Benefit* 60% of salary to a maximum of \$6,000**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 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.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- 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 acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- **I attest that the information provided above is true and correct to the best of my knowledge.**

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.

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: If you are not a resident of New York this statement does not apply to you: 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 Latte B. Baumg

DATE Feb 2, 2018

Enrollment Kit 00520266, 0001, EN