PO Box 30477 Tampa, FL 33630-3477
800.856.9981

Insurance Coverage (include all that apply)	Cost
Health	
Dental	
Term Life	
Long-Term Disability	
Fees	
Application Fee for new enrollees	$50
Paper Enrollment Fee (does not apply if you enroll online)	$5
Annual Access Fee for new enrollees	$75
Total	

** If you are enrolling in term life or long-term disability coverage, you may need to send us the Evidence of Insurability Form included with this packet. You need to complete this form if you meet any of the following criteria:

- You are already enrolled in health, dental, term life, and/or long-term disability coverage through Freelancers Union.
- You or your dependents are required to complete the form due to a medical reason (reasons are outlined on the Life and Disability Enrollment Form).
- You wish to enroll in term life insurance above $100,000. This is the highest amount of coverage Guardian will provide without additional medical information.
- You wish to enroll your spouse in term life insurance above $50,000. This is the highest amount of coverage Guardian will provide for a spouse without additional medical information.
- You wish to increase your (or your dependent's) term life or long-term disability coverage amount.

If you need to complete an Evidence of Insurability form in addition to your enrollment form, please review the steps below. If you have any questions, please contact us at 800.856.9981.

If Evidence of Insurability is required due to medical history, because you are increasing a current coverage amount, or because you are enrolled in other coverage through Freelancers Union:

1. Complete the enclosed Evidence of Insurability Form and return it with your enrollment packet.
2. Once your forms are received and processed at our Billing and Enrollment Office, they will be sent to Guardian for review. Please note that Guardian has the right to approve you or your dependents for a lower coverage amount or deny coverage based on your medical history.
3. Guardian will send you a letter to let you know if your coverage has been approved or denied.
4. If coverage is approved, you will receive a letter in your Inbox on the billing and enrollment website (**https://be.freelancersunion.org/insurance/billing/sso**) about the addition or increase of this coverage, including the date your coverage will begin.
5. If coverage is denied, the amount of your premium will be credited to your account.

If Evidence of Insurability is required due to coverage amount over $100,000 ($50,000 for spouse):

1. Complete the enclosed Evidence of Insurability form and return it with your enrollment packet.
2. Once your forms are received and processed at our Billing and Enrollment Office, you will be initially enrolled with a $100,000 coverage amount ($50,000 for a spouse) while your Evidence of Insurability Form is reviewed by Guardian. Please note that Guardian has the right to approve you or your spouse for a lower coverage amount or deny your request based on medical history.
3. Guardian will send you a letter to let you know if your desired coverage amount has been approved or denied.
4. If coverage is approved, you will receive a notification in your Inbox on the billing and enrollment website (**https://be.freelancersunion.org/insurance/billing/sso**) that will include your monthly premium and the date your increased coverage will begin.
5. If coverage is denied, or if Guardian has not processed your form before the end of your first coverage month, you will remain covered at the guaranteed issue amount and your account will be credited for the difference in premium.

Payment Election Form

If you are a new member of the Freelancers Union insurance group, please choose an initial payment option and an ongoing payment option. Please note that ongoing paper check payments will incur monthly fees, but electronic payments will not.

If you already receive health, dental, life, and/or disability coverage through Freelancers Union, please **do not** complete this form. You may change how you receive your invoice and make payments at **https://be.freelancersunion.org/insurance/billing/sso.**

Member Information

Member Name	**Member ID Number**

Initial Payment Information

Please choose your preferred payment option for your first month of coverage and any applicable fees.

☐ **Electronic Funds Transfer (EFT):** Your total amount due for your first month of coverage, including payments for your insurance premium(s) and any applicable fees, will be automatically deducted from your bank account.

EFT Account Type
☐ Checking ☐ Savings

Account Number
_ _ _ _ _ _ _ _ _

Routing Number
_ _ _ _ _ _ _ _ _

☐ **Paper Check:** Enclose a paper check for your total amount due for your first month of coverage including your insurance premium(s) and any applicable fees. Please use the payment calculator on page one to determine this amount.

Ongoing Payment Information

Please choose how you receive your invoice and/or make your payment once you are enrolled in coverage.

☐ **Recurring Electronic Funds Transfer (EFT):** Your total amount due is automatically deducted from your bank account on the 15th of each month (or next business day), including your monthly premium(s) for coverage and any applicable fees. You will also receive an email notification each month when your invoice has been posted to your account.

EFT Account Type
☐ Checking ☐ Savings

Account Number
_ _ _ _ _ _ _ _ _

Routing Number
_ _ _ _ _ _ _ _ _

☐ **E-Bill:** You receive an email notification each month when your invoice has been posted to your account. The email will provide a link to view and pay your invoice online at **https://be.freelancersunion.org/insurance/billing/sso**. You cannot pay by paper check if you choose this option.

☐ **Paper Bill:** You receive your invoice by mail and a $2 monthly paper bill fee will be applied to your account. You may pay by mailing us a check along with the payment coupon from the invoice you received. You will also receive an email notification each month when your invoice has been posted to your account and can pay online at **https://be.freelancersunion.org/insurance/billing/sso**.

To change how you receive your invoice and/or make your payment after you enroll, please visit our billing and enrollment website at **https://be.freelancersunion.org/insurance/billing/sso** or call us at 800.856.9981.

FREELANCERS
INSURANCE COMPANY

HEALTH INSURANCE ENROLLMENT FORM

APPLICANT INFORMATION

Last Name	First Name	M.I.	Gender
			☐ Female ☐ Male

Date of Birth *(MM/DD/YYYY)*	Social Security Number	Home Phone	Daytime Phone
	- -	( ) -	( ) -

Marital Status	E-Mail	Are you eligible for Medicare?
☐ Single ☐Married ☐ Domestic Partner		☐Yes ☐No

Street Address	Apt	City	State	Zip Code

INSURANCE INFORMATION

Select a Plan:
☐ FIC PPO1 ☐ FIC PPO 2 ☐ FIC PPO 3 ☐FIC HD 5000 ☐ FIC HD 10000

Plan Start Date: _____ *(MM/DD/YYYY)*

[Did you have health insurance prior to the coverage you are electing now? ☐Yes ☐No
If yes: Carrier Name _____ Effective Date _____ *(MM/DD/YYYY)* Termination Date _____ *(MM/DD/YYYY)*]

Will you be covered by any other health insurance in addition to the coverage you are electing now? ☐Yes ☐No
[If yes: Carrier Name _____ Policy Number _____ Effective Date _____ *(MM/DD/YYYY)*
Carrier Address _____]

DEPENDENT INFORMATION

Spouse/Domestic Partner:

Last Name	First Name	M.I.	Gender
			☐ Female ☐ Male

Date of Birth *(MM/DD/YYYY)*	Social Security Number	Relationship:	Is this dependent eligible for Medicare?
/ /	- -	☐ Spouse ☐ Domestic Partner	☐ Yes ☐ No

Dependent 1:

Last Name	First Name	M.I.	Gender
			☐ Female ☐ Male

Date of Birth *(MM/DD/YYYY)*	Social Security Number	Is this dependent a full-time student? ☐ Yes ☐ No Is this dependent disabled? ☐ Yes ☐ No
/ /	- -	

Dependent 2:

Last Name	First Name	M.I.	Gender
			☐ Female ☐ Male

Date of Birth *(MM/DD/YYYY)*	Social Security Number	Is this dependent a full-time student? ☐ Yes ☐ No Is this dependent disabled? ☐ Yes ☐ No
/ /	- -	

Dependent 3:

Last Name	First Name	M.I.	Gender
			☐ Female ☐ Male

Date of Birth *(MM/DD/YYYY)*	Social Security Number	Is this dependent a full-time student? ☐ Yes ☐ No Is this dependent disabled? ☐ Yes ☐ No
/ /	- -	

If you have additional dependents, please provide their information on a separate sheet of paper.

FREELANCERS
INSURANCE COMPANY

HEALTH INSURANCE ENROLLMENT FORM

ACKNOWLEDGEMENT *(Read carefully before signing.)*

I, the Primary Proposed Insured (or Spouse signing below), by my signature set forth thereafter: agree to the following: (a) All statements and answers in this application are complete and true to the best of my knowledge and belief. (b) Insurance will take effect only if a certificate is issue based on this application and the first premium is paid in full. (c) No agent has the authority to waive any answer or otherwise modify this application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application.

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

Signature _____

Print Name _____

Date ____/____/_____
MM DD YYYY

The Guardian Life Insurance Company of America

MAIL TO: FREELANCERS UNION BILLING AND ENROLLMENT OFFICE
P.O. BOX 30477
TAMPA, FL 33630-3477

GG-013499NY
Enrollment Form
For Dental Coverages

Planholder Name (Company Name)	Group Plan No.	Division	Class
Working Today	361887 / 429500		

Planholder Street Address	City	State	Zip
20 Jay Street, Suite 700	Brooklyn	NY	11201

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

PLEASE CHECK REASON FOR COMPLETING: ☐ INITIAL APPLICATION

CHANGE: ☐ ADD DEPENDENT(S) ☐ TERMINATE A FAMILY MEMBER ☐ ADDRESS ☐ NAME ☐ DELETE COVERAGE

DATE OF CHANGE __/__/__ **REASON FOR CHANGE** _____

GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED

Name (Last, First, Middle Initial)	Social Security #	Sex	Birthdate	
Member:		☐ M ☐ F		
Spouse:		☐ M ☐ F		Date of Marriage / /
Child:		☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
Child:		☐ M ☐ F		Full Time Student? ☐ Yes ☐ No

(1) Are any dependent children adopted? ☐ Yes ☐ No If "yes", indicate name and date of placement:
(2) Have you included stepchildren? ☐ Yes ☐ No If "yes", indicate name(s):
(3) Are they dependent on you for support and maintenance? ☐ Yes ☐ No

Hrs. Worked / Week	Occupation /Job Title

Member's Street Address	City

State	Zip	Business Phone #	Home Phone #

DENTAL

☐ **I elect PPO Plan.**
☐ **I elect MDG Plan. (Must Select Dental Office)**
Employee's Dental Office #_____

SPOUSE: ☐ Yes ☐ No *** **Spouse's Dental Office #**_____

CHILD(REN): ☐ Yes ☐ No *** **Child(ren)'s Dental Office #**_____

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.

** 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 DenalGuard, Inc. (In NJ); or (c) Managed DentalGuard plans underwritten by The Guardian Life Insurance Company of America (in FL and NY); or (d) First Commonwealth Insurance Company (in IL); or (e) First Commonwealth of Missouri (in MO); or (f) First Commonwealth Limited Health Service Corporation (in IN and in WI); or (g) in Michigan, First Commonwealth, Inc. underwritten by Capitol Indemnity Corporation (not a wholly owned subsidiary of Guardian). Eligibility for this coverage is only available at the open enrollment period.

- I hereby apply for the group benefit(s) indicated above.
- I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance.
- The information provided above is true and correct to the best of my knowledge.
- 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 be guilty of insurance fraud.
- Dependents cannot be enrolled for coverage(s) if the employee is not enrolled for that coverage(s).

X SIGNATURE OF MEMBER	DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM

Date that you became a Member of Working Today _____/_____/_____

Date applying for Dental Coverages _____/_____/_____

The Guardian Life Insurance Company of America

MAIL TO: FREELANCERS UNION BILLING AND ENROLLMENT OFFICE
P.O. BOX 30477
TAMPA, FL 33630-3477

GG-013500NY
Enrollment Form
For Non-Medical Coverage

Planholder Name (Company Name)	Group Plan No.	Division	Class
Working Today	425611		

Planholder Street Address	City	State	Zip
20 Jay Street, Suite 700	Brooklyn	NY	11201

PLEASE CHECK REASON FOR COMPLETING: ☐ INITIAL APPLICATION CHANGE : ☐ INCREASE ☐ ADD DEPENDENT (S)/RIDER(S) ☐ PREMIUM CLASS

GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED

Name (Last, First, Middle Initial)	Sex	Birthdate	Participant's Social Security #
Participant:	☐ M ☐ F		
Spouse:	☐ M ☐ F		Date of Marriage / /
Child:	☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
Child:	☐ M ☐ F		Full Time Student? ☐ Yes ☐ No

(1) Are any dependent children adopted? ☐ Yes ☐ No If "yes", indicate name and date of placement:

(2) Have you included stepchildren? ☐ Yes ☐ No If "yes", indicate name(s): Are they dependent on you for support and maintenance? ☐ Yes ☐ No

Date of Full Time Employment	Hrs. Worked / Week	Annual Salary	Occupation /Job Title
		$	

Participant's Street Address	City	Beneficiary Name (Last, First, Middle), Relationship and %
		1. _____ ____ %
		2. _____ ____ %

State	Zip	Business Phone #	Home Phone #

VOLUNTARY TERM LIFE Issued by: The Guardian Life Insurance Company of America

Have you or your spouse used any form of tobacco in the past 6 months (e.g., pipe, chewing tobacco) or smoked cigarettes in the past 12 months?

Participant ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No *If "yes", specify:* Type: Amount Used:

In the last 6 months, have you or any of your dependents: (a) (excluding HIV), received medical treatment, consultation, care or services, including diagnostic measures or took prescribed drugs for: cardiovascular disease; cancer or any other life threatening condition?; or (b) been treated for (including prescription drugs) or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex?

Employee ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child(ren)** ☐ Yes ☐ No

AN EVIDENCE OF INSURABILITY FORM(S) MUST BE COMPLETED FOR ANY PARTICIPANT OR DEPENDENT(S) WITH A "YES" ANSWER TO THE ABOVE QUESTION.

Participant/Employee Life:

☐ $50,000 ☐ $100,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $400,000 ☐ $500,000 ☐ $750,000 ☐ $1,000,000 ☐ I decline coverage. *

Spouse Life: (50% to employee amount to a maximum of $250,000)

☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ I decline coverage. *

Child(ren) Life: (10% to a maximum of $4,000) (1-13 days not covered) (14 days – 6 months is a $500 benefit)

☐ I elect coverage. ☐ I decline coverage. *

LONG TERM DISABILITY:

☐ $500 ☐ $750 ☐ $1,000 ☐ $1,250 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000

☐ 30 Day Elimination Period ☐ 90 Day Elimination Period

☐ I decline coverage. *

*** DECLINATION OF COVERAGE:**

If I have waived the 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.

- I hereby apply for the group benefit(s) indicated above.
- I understand I must be actively at work or my coverage will not take effect and my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service.
- I understand that insurance coverage for my dependents will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex.
- I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance.
- The information provided above is true and correct to the best of my knowledge.
- 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 PARTICIPANT	DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM

CEF-NY-1999

Read and Detach for your records

Thank you for choosing Guardian insurance. This notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Corporate Secretary, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-2616.

Medical Information Bureau Pre-notice: The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. On the request of any of its member companies to which you apply for life or health insurance, or to which you make a claim for benefits, the Bureau will supply the inquiring company with the information in its files.

Guardian or our reinsurers may make a brief report of objective findings about you to the Bureau. We will not report what action we have taken on your application.

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is Post Office Box 105, Essex Station, Boston, MA 02112, telephone 617-426-3660.

Medical Records: We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

I hereby represent that the statements and answers to the questions on the attached form are, to the best of my knowledge and belief, full, complete and true. I understand that they shall form the basis upon which I may be included for insurance.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (in the case of a late entrant, it is not at the Insurance Company's expense), that I be examined by an accredited medical examiner selected by the Company, (2) no Group Insurance shall be binding or in force until satisfactory evidence of insurability is submitted and approved by the Insurance Company at the Home Office as shown in the Endorsement, and: (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I will become insured on the date I do return to work and satisfy a waiting period (as defined in the Group Plan) of full-time service. (3) coverage for my dependents will not take effect if a dependent other than a newborn is: (a) confined to the hospital or other health care facility; or (b) is unable to perform the normal activities of someone of like age and sex. (4) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (5) the employer is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

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

I authorize any physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, insurance or rei nsurance company, or employer to release any and all medical and non-medical information in its possession about me or my eligible dependents to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my eligible dependents.

I understand The Guardian Life Insurance Company of America will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

I know that I may request and receive a copy of this authorization.

I agree that a photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of Guardian's notice regarding its insurance information practices, and medical records.

I agree that this authorization shall be valid for two and one half years from the date signed.

The Guardian Life Insurance Company of America
The Guardian Insurance & Annuity Company, Inc.

EVIDENCE OF INSURABILITY
FOR NON-MEDICAL COVERAGES

Please complete in ink. Erasures and changes invalidate this form.

Planholder Name (Company Name)	Group Plan No.

Complete the following information for each person to be underwritten:

Name (Last, First, Middle Initial)	Sex	Birthdate	Height	Weight	Full Time Student?
Employee:	☐ M ☐ F				
Spouse:	☐ M ☐ F				
Child:	☐ M ☐ F				☐ Yes ☐ No
Child:	☐ M ☐ F				☐ Yes ☐ No

Employee's Social Security Number	Date of Marriage	Employee's Place of Birth (State)

IF APPLYING FOR LIFE INSURANCE: questions 1-4 must be answered for each person to be underwritten
IF APPLYING FOR DISABILITY INSURANCE: all five questions must be answered in reference to the employee only

1. In the past 10 years been treated for or diagnosed as having: heart; liver or kidney disorder; neurological disorder; diabetes; stroke; cancer; tumor; mental or nervous disorder; or been advised to have treatment for drug abuse (including prescription drugs); or alcoholism?	Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No Child ☐ Yes ☐ No
2. In the past 5 years used illegal drugs?	Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No Child ☐ Yes ☐ No
3. (a) Ever tested positive for HIV (Human Immunodeficiency Virus) antibodies? (b) In the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); lymphadenopathy (enlarged or swollen glands)?	Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No Child ☐ Yes ☐ No
4. In the past year: (a) consulted or been examined by or treated by a physician, practitioner or specialist? (Include routine physicals only when there is an existing or newly diagnosed medical condition); (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation?; (c) been prescribed medication(s) - (other than for colds, flu or allergies)?	Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No Child ☐ Yes ☐ No
5. If applying for disability coverage, please complete these additional questions: (a) In the past 5 years, been treated for conditions of the back, neck, spine, or arthritis?; (b) Are you currently pregnant?; (c) Excluding your employer sponsored group disability plan, are you currently insured for any other disability coverage? If yes, what is the total amount of coverage already in-force? $_____	Employee ☐ Yes ☐ No

For each "yes" answer to questions 1 through 5b give details below. (*Continue on reverse side if additional space is needed.)

Ques. No.	Name of Patient	Practitioner's Name & Address	Hospital Name & Address	Condition	Duration of symptoms, treatment & degree of recovery	Dates mo/yr

I authorize any physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my eligible dependents to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my eligible dependents. I agree that this authorization will be valid for two and one half years from the date shown below and I have read, understand, and accept the statements and provisions on the reverse side of this application.

Signature of Employee x _____ Date

Signature of Spouse x _____ Date

ENDORSEMENT (GUARDIAN USE ONLY)

Employee ☐ Approved ☐ Declined Premium Class: ☐ Preferred ☐ Standard Optional Life: $ Guardian's Universal Life: $	Child: ☐ Approved ☐ Declined Optional Life: $ Child Term Rider: $
Spouse: ☐ Approved ☐ Declined Premium Class: ☐ Preferred ☐ Standard Optional Life: $ Spouse Term Rider: $	Excess Life $_____ ☐ Approved ☐ Declined Long Term Disability $_____ ☐ Approved ☐ Declined Short Term Disability $_____ ☐ Approved ☐ Declined

Effective Date:	By:	Date:	Secretary

GG 012993

Please retain a photocopy for your records and submit this form

I hereby represent that the statements and answers to the questions on the reverse side are, to the best of my knowledge and belief, full, complete and true. I understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (in the case of a late entrant, it is not at the Company's expense), that I be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted and approved by the Insurance Company at the Home Office as shown in the Endorsement; and (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I will become insured on the date I do return to work and satisfy a waiting period (as defined in the Group Plan) of full-time service; (3) coverage for my dependents will not take effect if a dependent other than a newborn is: (a) confined to the hospital or other health care facility; or (b) is unable to perform the normal activities of someone of like age and sex; (4) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (5) the employer is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

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

I understand The Guardian Life Insurance Company of America will use the information obtained by this authorization to determine eligibilit y for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

I know that I may request and receive a copy of this authorization.

I agree that a photocopy of this authorization will be as valid as the original.

I acknowledge receipt of Guardian's notice regarding its insurance information practices, and medical records.

---

* Additional space if questions 1 through 5b were answered "yes".

Ques. No.	Name of Patient	Practitioner's Name & Address	Hospital Name & Address	Condition	Duration of symptoms, treatment & degree of recovery	Dates mo/yr

PO Box 30477 Tampa, FL 33630-3477
800.856.9981

Dependent Documentation Guide

If you enroll a dependent in one or more of your insurance plans, you may need to submit documents to verify that your dependent is eligible for coverage. The kind of documentation required depends on the type of insurance coverage, when the dependent was added, and the type of dependent—please see the information below for specifics. **All documents must be received within 30 days of enrolling your dependent online or by mail*.**

Please send your documents, along with your name, Freelancers Union Member ID number, and dependent's name to Freelancers Union Billing and Enrollment Office.

Mail: PO Box 30477
Tampa, FL 33630-3477

Fax: 718.228.8502

Email: benefits@freelancersunion.org

Dependent type:

- **Child (for health, dental, and life insurance):**
  Added when you enrolled or during open enrollment
  - **Same last name:** No documentation required.
  - **Different last name:** Birth certificate or adoption or guardianship papers.

  Added due to a qualifying event
  - **New child:** Birth certificate or adoption or guardianship papers.
  - **Loss of coverage:** The documentation outlined above **and** proof of loss of prior coverage in the form of a HIPAA Certificate or other written proof from your dependent's previous insurer.
- **Child enrolled as a full-time student (dental and life insurance):** If you enrolled a child age 20 or older, you will be asked to complete a form and/or provide proof that your dependent is a full-time student. You will be notified directly by Guardian or Freelancers Union when it becomes necessary to provide this information.
- **Child age 26-29 (health insurance):** Young adult dependents age 26-29 cannot be added to your coverage through our website. Please consult the *Guide to Young Adult Dependent Coverage* for information on enrollment and required documentation:
  http://fu-res.org/pdfs/insurance/health/2010/young-adult-coverage.pdf

- **Spouse (health, dental, and life insurance):**
  Added when you enrolled or during open enrollment
  - **Same last name:** No documentation required.
  - **Different last name:** Marriage license.

  Added due to a qualifying event
  - **Marriage:** Marriage license.
  - **Loss of coverage:** The documentation outlined for initial enrollment **and** proof of loss prior coverage in the form of a HIPAA Certificate or other written proof from your spouse's previous insurer.

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800.856.9981

- **Spouse age 65 or older (health insurance):** The documentation outlined above **and** proof that he or she is not eligible for Medicare. This proof can be his or her Social Security Statement or a physician's statement with proof of disability or end-stage renal disease.

- **Domestic Partner (health and dental insurance):**

  Added at any time, whether or not you have the same last name:

  - State domestic partner registration.

  or

  - Domestic partner affidavit, proof of cohabitation, and proof of joint responsibility for common welfare and financial obligations as demonstrated by at least two of the following:
    - A joint mortgage or lease;
    - Evidence of shared rental payments of joint residence;
    - Evidence of a common household and shared household expenses;
    - Evidence of status of domestic partner as representative payee for the your government benefits;
    - Evidence of joint responsibility for child care;
    - Evidence of a shared household budget for the purpose of receiving government benefits;
    - Designation of domestic partner as beneficiary for life insurance or retirement benefits;
    - Joint wills, or will designating domestic partner as executor and/or primary beneficiary;
    - Designation of domestic partner as your representative in a durable power of attorney or health care proxy;
    - Ownership of joint bank account, joint credit card, joint ownership of a motor vehicle (or other major item of personal property), or other evidence of joint financial responsibility;
    - Affidavit by shared creditor swearing to financial interdependence between you and domestic partner;
    - Other items of proof sufficient to establish economic interdependency.

- **Domestic Partner age 65 or older (health insurance):** The documentation outlined above and proof that he or she is not eligible for Medicare. This proof can be his or her Social Security Statement or a physician's statement with proof of disability or end-stage renal disease.

*Please note: the enrollment date is the day you enroll your dependent through our website or the date we receive your paper enrollment form, not the date the dependent's coverage begins.

If you have any questions, please contact us at 800.856.9981.