

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

Please print clearly and mark carefully.

Employer Name: CITY OF CRESTVIEW	Group Plan Number: 00372073	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information 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 (indicate primary): <input type="checkbox"/> Home (____) ____ - ____ <input type="checkbox"/> Work (____) ____ - ____ <input type="checkbox"/> Mobile (____) ____ - ____			
Email Address (indicate primary) <input type="checkbox"/> Home _____ <input type="checkbox"/> Work _____			
Are you married or do you have a partner? <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:	Job Title: _____
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra/State Continuation	Date of full time hire: ____ - ____ - ____
Hours worked per week: _____	

About Your Family: Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (wherever the term Spouse appears on this form, it also includes Partner).	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	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:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	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:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	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:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	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: _____</p> <p>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>Loss Of Other Coverage:</p> <p>I and/or my dependents were previously covered under Loss of coverage was due to:</p> <p><input type="checkbox"/> Termination of Employment: ____ - ____ - ____</p> <p><input type="checkbox"/> Divorce/Separation ____ - ____ - ____</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</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</p> <p><input type="checkbox"/> Other _____</p> <p>(additional information may be required)</p>

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

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.
- 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 if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.
- I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.
- 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 consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days 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 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 _____ DATE _____