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

Please print clearly and mark carefully.

Employer/Planholder Name: **Employer Solutions Staffing Group**	Group Plan Number: **00466845**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment ☐ Add Employee/Member Dependents/Family Members ☐ Drop/Refuse Coverage ☐ Information Change

In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term , and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.

Class: ALL ELIGIBLE
NON-CORPORATE EMPLOYEES
EXCEPT FLT-MED EMPLOYEES

Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer/Planholder)**

About You:

Full Legal Name-First, MI, Last Name:

What is the name you go by? (optional)

Employer/Planholder Provided Identification:

_____

Social Security Number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.

Address	City	State	Zip

Gender Identity: ☐ M ☐ F Date of Birth (mm-dd-yy): ____ - ____ - ____

Phone (indicate primary): ☐ Home (____) ____ - ____
☐ Work (____) ____ - ____
☐ Mobile (____) ____ - ____

Email Address (indicate primary) ☐ Home _____ ☐ Work _____

Are you married or in a civil union? ☐ Yes ☐ No Date of marriage/civil union:____-____-_____
Do you have children or other dependents? ☐ Yes ☐ No Placement date of adopted child: ____-____-_____

About Your Job:

Job Title:

Work Status: ☐ Active ☐ Retired ☐ COBRA/State Continuation Hours worked per week: _____	Date of full time hire: _____ - _____ - _____	Annual Salary: $_____

About Your Family:

Please include the names of the dependents you wish to enroll for coverage. Your dependent's Social Security Number must be provided if enrolling for Life Coverage. Additional information may be required for dependents.

Spouse Address/City/State/Zip: Phone: ( ) -		Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Oct 16, 2023

Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender Identity: ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

Drop Coverage:

☐ Drop Employee/Member ☐ Drop Dependents/Family Members

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

☐ Termination of Employment ☐ Retirement

Last Day Worked: _____-_____-_____

☐ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

☐ Dental	☐ Employee/Member	☐ Spouse	☐ Child(ren)
☐ Vision	☐ Employee/Member	☐ Spouse	☐ Child(ren)
☐ Basic Term Life			
☐ Voluntary Term Life			
☐ Critical Illness			
☐ Accident	☐ Employee/Member	☐ Spouse	☐ Child(ren)
☐ Long Term Disability			
☐ Short Term Disability			

Loss Of Other Coverage:

I and/or my dependents were previously covered under Loss of coverage was due to:

☐ Termination of Employment: _____-_____-_____

☐ Divorce/Separation _____-_____-_____

☐ Death of Spouse _____-_____-_____

☐ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ☐ Dental ☐ Vision

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

☐ Covered under another insurance plan

☐ Other _____

(additional information may be required)

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

	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Dependent/Child(ren)	Employee/Member, Spouse & Dependent/Child(ren)
PPO	☐	☐	☐	☐

☐ I do not want Dental Coverage because (Check as applicable):

- ☐ I am covered under another Dental plan
- ☐ My spouse is covered under another Dental plan
- ☐ My dependents/family members are covered under another Dental plan

Vision Coverage: You must be enrolled to cover your dependents/family members. Check only one box.

	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Dependent/Child(ren)	Employee/Member, Spouse & Dependent/Child(ren)
Full Feature	☐	☐	☐	☐

☐ I do not want this Vision coverage because (Check as applicable):

- ☐ I am covered under another Vision plan
- ☐ My spouse is covered under another Vision plan
- ☐ My dependents/family members are covered under another Vision plan

LIFE INSURANCE *continued*

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D): *Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Employee/Member

Policy Amount *Check one box only*

☐ $50,000*

Guarantee Issue up to: Employee Less than age 65 $50,000*, 65-69 $50,000, 70+ $10,000. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

☐ I do not want this coverage

Important Notes:

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

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

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-yyyy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

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

Phone: ( ) - Relationship to Employee/Member:_____

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

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

Phone: ( ) - Relationship to Employee/Member:_____

Contingent Beneficiary:_____ Social Security Number: ___ ___ ___-___ ___-___ ___ ___ ___

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

Phone: ( ) - Relationship to Employee/Member:_____

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

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only ☐ Yes ☐ No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:
Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): ____ ____ ____ ____ ____-____ _____
____
Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____
Phone: ( ) -

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Short-Term Disability (STD) Coverage:

The amount of STD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Weekly Benefit

☐ 60% of salary to a maximum of $500

☐ I do not want this coverage.

Long-Term Disability (LTD) Coverage:

The amount of LTD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Monthly Benefit

☐ 60% of salary to a maximum of $5,000

☐ I do not want this coverage.

Critical Illness Coverage: You must be enrolled to cover your dependents/family members

Benefit reductions apply. Please see plan administrator.

Employee/Member Insurance Amount: ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000

☐ I do not want this coverage.

Spouse Insurance Amount: Up to 50% of the employee/member's amount to a maximum of $10,000

☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

☐ do not want this coverage.

Dependent/Child(ren) Insurance Amount: ■ 25% of the employee/member's amount

☐ I do not want this coverage.

Employee/Member Only - Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

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-yyyy) the paper and keep a copy for your records

Primary Beneficiaries:

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

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

Phone: ( ) - Relationship to Employee/Member:_____

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

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

Phone: ( ) - Relationship to Employee/Member:_____

Contingent Beneficiary:_____ Social Security Number: ___ ___ ___-___ ___-___ ___ ___ ___

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

Phone: ( ) - Relationship to Employee/Member:_____

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

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Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ☐ Yes ☐ No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:
Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): ____ ____ ____ ____ ____-____ _____ ____
Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____
Phone: ( ) -

Accident Coverage

You must be enrolled to cover your family members.

Your Monthly premium	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Dependent/Child(ren)	Employee/Member, Spouse & Dependent/Child(ren)
Option 1: Basic	☐	☐	☐	☐
Option 2: Advantage	☐	☐	☐	☐

☐ I do not want this coverage.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

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-yyyy) the paper and keep a copy for your records

Primary Beneficiaries:

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

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

Phone: ( ) - Relationship to Employee/Member:_____

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

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

Phone: ( ) - Relationship to Employee/Member:_____

Contingent Beneficiary:_____ Social Security Number: ___ ___ ___-___ ___-___ ___ ___ ___

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

Phone: ( ) - Relationship to Employee/Member:_____

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

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

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Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): ____ ____ ____ ____ ____-____ _____ ____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: ( ) -

Signature

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that insurance coverage for an adopted child begins on the date of placement for adoption.
- I understand that insurance coverage, other than life insurance coverage, for a newborn child begins at the moment of birth.
- 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.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a 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.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- **I state that the information provided above is true and correct to the best of my knowledge or belief.**

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material hereto, may be guilty of committing a fraudulent insurance act as determined by a court of law, which may be a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The following section applies to these coverage(s): Accident Coverage, Cancer Coverage, Critical Illness Coverage, Hospital Indemnity Coverage:

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

SIGNATURE OF EMPLOYEE/MEMBER X _____ DATE _____

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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

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.

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.

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.

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.

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.

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.

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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER