

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

Please print clearly and mark carefully.

Employer Name: CITY OF TWINSBURG		Group Plan Number: 00525131	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)

<b>About You:</b> First, MI, Last Name:		Social Security Number ____ - ____ - ____	
Address	City	State	Zip
Gender: M F	Date of Birth (mm-dd-yy): ____ - ____ - ____	Phone: ( ) - ____ - ____	
Email Address:	Are you married or do you have a spouse? Yes No	Date of marriage/union: ____ - ____ - ____	
	Do you have children or other dependents? Yes No	Placement date of adopted child: ____ - ____ - ____	

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

**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		Gender M F	Social Security Number ____ - ____ - ____	
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: ( ) - ____ - ____				
Child/Dependent 1:	Add Drop	Gender M F	Social Security Number ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent State of Residence: _____
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: ( ) - ____ - ____				
Child/Dependent 2:	Add Drop	Gender M F	Social Security Number ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent State of Residence: _____
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: ( ) - ____ - ____				

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

<b>Drop Coverage:</b> Drop Employee      Drop Dependents 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: ____ - ____ - ____	<b>Coverage Being Dropped:</b> Dental                  Employee      Spouse      Child(ren) Vision                  Employee      Spouse      Child(ren) Basic Life Voluntary Life          Employee      Spouse      Child(ren)
<b>Loss Of Other Coverage:</b> I and/or my dependents were previously covered under <u>another insurance plan</u> . 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. Check only one box.

Employee Only      EE, Spouse & Dependent/Child(ren)

PPO

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

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

Employee Only      EE, Spouse & Dependent/Child(ren)

Full Feature

I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:

I am covered under another Vision plan

My spouse is covered under another Vision plan

My dependents are covered under another Vision plan

**Basic Life Coverage:**

*Benefit reductions apply. Please see plan administrator.*

Policy Amount

Employee Only

\$75,000

The Guarantee Issue

Amount is \$75,000.

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.

**Voluntary Term Life Coverage:** You must be enrolled to cover your dependents. *Benefit reductions apply. Please see plan administrator.*

Employee

Policy Amount

*Check one box only*

\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000
\$70,000	\$80,000	\$90,000	\$100,000	\$110,000	\$120,000
\$130,000	\$140,000	\$150,000*	\$160,000	\$170,000	\$180,000
\$190,000	\$200,000	\$210,000	\$220,000	\$230,000	\$240,000
\$250,000	\$260,000	\$270,000	\$280,000	\$290,000	\$300,000
\$310,000	\$320,000	\$330,000	\$340,000	\$350,000	\$360,000
\$370,000	\$380,000	\$390,000	\$400,000	\$410,000	\$420,000
\$430,000	\$440,000	\$450,000	\$460,000	\$470,000	\$480,000
\$490,000	\$500,000				

Guarantee Issue up to: Employee Less than age 65 \$150,000\*, 65-69 \$50,000, 70+ \$10,000.

I do not want this coverage

**Add Voluntary Life for Spouse**

Policy Amount

\$10,000*	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000
\$70,000	\$80,000	\$90,000	\$100,000	\$110,000	\$120,000
\$130,000	\$140,000	\$150,000	\$160,000	\$170,000	\$180,000
\$190,000	\$200,000	\$210,000	\$220,000	\$230,000	\$240,000
\$250,000	\$260,000	\$270,000	\$280,000	\$290,000	\$300,000
\$310,000	\$320,000	\$330,000	\$340,000	\$350,000	\$360,000
\$370,000	\$380,000	\$390,000	\$400,000	\$410,000	\$420,000
\$430,000	\$440,000	\$450,000	\$460,000	\$470,000	\$480,000
\$490,000	\$500,000				

\*Guarantee Issue Amount

\*The amount may not be more than 100% of the employee amount for Voluntary Life.

I do not want this coverage

**LIFE INSURANCE** *continued*

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

\$5,000

\$10,000\*

\*Guarantee Issue Amount

\*The amount may not be more than 100% of the employee amount for Voluntary Life.

I do not want this coverage

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

Employee Yes No

Spouse Yes No

Important Notes:

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

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

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.)

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

**Signature**

I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

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 life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.

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.

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 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, 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.

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 \_\_\_\_\_

DATE \_\_\_\_\_

Enrollment Kit 00525131, 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.

**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.

**Connecticut, Iowa, Kansas, Nebraska, 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.

**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.

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.

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.

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.