GG015049VA
Enrollment / Change Form

The Guardian Life Insurance Company of America

Planholder Name (Company Name)			Guardian Group Plan No.:
United Leasing Corporation			445982
Planholder Street Address	City	State	Zip
9205 Chamberlayne Road	Mechanicsville	VA	23116

EMPLOYER USE ONLY: ☐ New Application ☐ Add Dependent(s) ☐ Remove Dependent(s) ☐ Change Address ☐ Change Name ☐ Drop Coverage as of: / /

Class	Hours Worked	Division	Benefit Effective

Keep a copy for your records and return to: **Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012**

ABOUT YOURSELF - Please print clearly and in black or blue ink

First, Middle Initial, Last Name	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	Social Security Number

Address	City	State	Zip

The best way to reach you: ☐ Day Phone ☐ Evening Phone ☐ Email	Business Phone#	Home Phone #	Preferred Email

Job Title:	Work Status/Eligibility: ☐ Full Time ☐ Part Time ☐ Retired ☐ Cobra/State Continuation	Date work status began:	Annual Salary/Earnings: $

ARE YOU MARRIED? ☐ Yes ☐ No

DO YOU HAVE CHILDREN OR OTHER DEPENDENTS? ☐ Yes ☐ No

ABOUT YOUR DEPENDENTS

	Name	Sex	Date of Birth (mm/dd/yyyy)			
☐ Add ☐ Change ☐ Drop	Spouse First, Middle Initial, Last Name	☐ M ☐ F	Date of Birth (mm/dd/yyyy)	Social Security Number	Marriage Date	
☐ Add ☐ Change ☐ Drop	Child (1):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since
☐ Add ☐ Change ☐ Drop	Child (2):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since
☐ Add ☐ Change ☐ Drop	Child (3):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since
☐ Add ☐ Change ☐ Drop	Child (4):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since

To drop coverage for yourself or your dependents, check the box(es) to the left of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverage's. ☐ Basic Life ☐ Long Term Disability ☐ Short Term Disability ☐ Dental

CHOOSE YOUR BASIC LIFE with Accidental Death & Dismemberment COVERAGE:

Employee: ☒ **Employer Provided**

IMPORTANT NOTE:

- If you waive life coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian reserves the right to reject your request.

NAME YOUR BENEFICIARIES – MUST ADD UP TO 100%

PRIMARY BENEFICIARY 1	PRIMARY BENEFICIARY 2	CONTINGENT BENEFICIARY
Name (Last, First, MI)	Name (Last, First, MI)	Name (Last, First, MI)
Relationship to you: %	Relationship to you: %	Relationship to you: %

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

PLEASE READ AND SIGN THE SIGNATURE SECTION ON THE REVERSE SIDE OF THIS FORM

CHOOSE YOUR SHORT TERM DISABILITY COVERAGE:

Employee: ☐ **I elect coverage.** ☐ **I Waive This Coverage.**

LONG TERM DISABILITY

Employee: ☐ **I elect coverage.** ☐ **I Waive This Coverage.**

CHOOSE YOUR DENTAL COVERAGE: Check one box only
Find dental providers online at www.guardianlife.com or check the directory of providers.

	PPO	
Employee Alone	☐	☐ **I Waive This Coverage**
Employee & Spouse	☐	☐ **I Waive This Coverage**
Employee & Child(ren)	☐	☐ **I Waive This Coverage**
Entire Family	☐	☐ **I Waive This Coverage**

If waiving coverage, are you covered under another dental plan? ☐ Yes ☐ No
If waiving dependent coverage, are your dependents covered under another dental plan? ☐ Yes ☐ No

If you or your family has lost dental coverage, please explain below. *Late entrant penalties may apply.*

Reason for Loss of coverage: **Date of coverage loss:**

☐ Termination of Employment. ☐ Divorce. ☐ Death of Spouse. ☐ Termination or Expiration of coverage

IMPORTANT NOTES:

- Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.
- Vision Discount Access is included with your dental plan at no charge. You must elect dental in order to qualify for Vision Discount Access.

SIGNATURE

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverage's that I have chosen above.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- I attest that the information provided above is true and correct to the best of my knowledge.
- I understand I must be actively at work or my life and/or disability coverage will not take effect until I have completed a waiting period (as defined in the group plan) of full time service. This requirement does not apply to eligible retirees
- I understand that my dependent(s) cannot be enrolled for coverage if I am not enrolled for that coverage.
- 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. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
- **Any person who, with the 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 have violated state law.**

SIGNATURE OF EMPLOYEE	DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN