



The Guardian Life Insurance Company of America

And its Affiliates and Subsidiaries!

P.O. Box 14319
Lexington, KY 40512

Enrollment/Change Form

Please print clearly and mark carefully.

Employer Name: World Pet Association
Group Plan Number: 00652626
Benefits Effective:

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

Class: 001 Division: (Please obtain this from your Employer)

About You:
First, MI, Last Name:
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/domestic partner? Yes No Date of marriage/union: - -
Do you have children or other dependents? Yes No Placement date of adopted child: - - -

About Your Job:
Hours worked per week: Job Title:
Work Status: Active Retired Cobra/State Continuation
Date of full time hire: - - -

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.

Table with 4 columns: Spouse/domestic partner (First, MI, Last Name), Gender, Date of Birth (mm-dd-yyyy), Status (check all that apply). Rows include Spouse and four Child/Dependent entries.

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

	Employee Only	EE & Spouse/domestic partner	EE & Dependent/Child(ren)	EE, Spouse/domestic partner & Dependent/Child(ren)
Option 1	<b>DPPO</b> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Option 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- I am covered under another Dental plan.
- My spouse/domestic partner 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.
- ! 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 insurability. Guardian has the right to reject your request.
- ! 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.
- ! Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. 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.
- ! 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 acknowledge and consent to receiving electronic copies of Guardian coverage related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing Guardian thirty (30) day prior written notice.
- ! **I attest that the information provided above is true and correct to the best of my knowledge.**
- ! **"California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."**

For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.!

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

SIGNATURE OF EMPLOYEE X \_\_\_\_\_ DATE \_\_\_\_\_