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

Please print clearly and mark carefully.

Employer Name: CHOICES IN COMMUNITY LIVING, INC.	Group Plan Number: 00568065	Benefits Effective:_____
PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Add Employee Dependents ❑ Drop/Refuse Coverage ❑ Information Change		

Class: ALL OTHER EMPLOYEES Division:_____ Subtotal Code:_____ (Please obtain this from your Employer)

About You: First, MI, Last Name:	Employer 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: ❑ M ❑ F Date of Birth (mm-dd-yy): ____ - ____ - ____

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

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

Are you married or do you have a partner? ❑ Yes ❑ No Date of marriage/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. 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 ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 2:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Oct 13, 2023

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

Drop Coverage:

❑ 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: _____-_____-_____

Coverage Being Dropped:

❑ Dental	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Vision	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Basic Life			
❑ Voluntary Life	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Critical Illness			
❑ Accident	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Hospital Indemnity	❑ Employee	❑ 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. Check only one box.

Your Bi-weekly Premium	Employee Only	Employee and 1 Dependent	Employee, Spouse & Dependent/Child(ren)
Option 1: Value	❑ $13.25	❑ $25.64	❑ $45.25
Option 2: NAP	❑ $13.25	❑ $25.64	❑ $45.25

❑ I do not want Dental Coverage because (Check 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.

Your Bi-weekly Premium	Employee Only	Employee & Spouse	Employee & Dependent/Child(ren)	Employee, Spouse & Dependent/Child(ren)
Full Feature - Designer	❑ $3.10	❑ $6.20	❑ $6.35	❑ $9.46

❑ I do not want this Vision coverage because (Check 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

Guardian Group Plan Number: 00568065

Please print employee name:

Basic Life Coverage:

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 as stated in the certificate of coverage covering you or your dependents.

Policy Amount
Employee Only
☑ $15,000
The Guarantee Issue Amount is $15,000.

* If Employee is 65+ benefit reductions may apply which may change the GI amount. Please see enrollment materials for details.

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

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.

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.

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: ( ) -

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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D): You must be enrolled to cover your dependents.
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 as stated in the certificate of coverage covering you or your dependents.

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*			

Guarantee Issue up to: Employee Less than age 65 $150,000*, 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

Add Voluntary Life for Spouse

Policy Amount

❑ $5,000	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000*

Guarantee Issue up to: Spouse Less than age 65 $30,000*, 65-69 $10,000.

**The amount may not be more than 50% of the employee amount for Voluntary Life.*

❑ I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

❑ $10,000*

**Guarantee Issue Amount*

**The amount may not be more than 10% of the employee amount for Voluntary Life.*

❑ 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.

LIFE INSURANCE *continued*

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.

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:_____

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.

Please contact your employer for any record of or changes to your beneficiary information.

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: ( ) -

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 as stated in the certificate of coverage covering you.

Weekly Benefit

☑ 60% of salary to a maximum of $1,000

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 as stated in the certificate of coverage covering you.

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

Benefit reductions apply. Please see plan administrator.

Employee Insurance Amount: ❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000 ❑ $25,000 ❑ $30,000

❑ I do not want this coverage.

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Spouse
Insurance Amount: Up to 100% of the employee's amount to a maximum of $30,000

❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000 ❑ $25,000 ❑ $30,000

❑ I do not want this coverage.

Dependent/Child(ren)
Insurance Amount: ❑ 50% of the employee's amount

❑ I do not want this coverage.

Accident Coverage

You must be enrolled to cover your dependents.

Your Bi-weekly premium	Employee Only	Employee & Spouse	Employee & Dependent/Child(ren)	Employee, Spouse & Dependent/Child(ren)
	❑ $6.03	❑ $10.48	❑ $14.49	❑ $18.94

❑ I do not want this coverage.

Hospital Indemnity Coverage

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

Your Bi-weekly premium	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee, Spouse & Child(ren)
	❑ $8.77	❑ $17.67	❑ $14.09	❑ $22.99
	❑ I do not want this coverage.	❑ I do not want this coverage.	❑ I do not want this coverage.	❑ I do not want this coverage.

Applicants over the age of 69 are not eligible to enroll in the Hospital Indemnity coverage.

Signature

- I understand that my dependents cannot be enrolled for a coverage if I am not enrolled for that coverage.
- An employee's decision to elect Vision and/or Hospital Indemnity not elect Vision and/or Hospital Indemnity must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in Vision and/or Hospital Indemnity coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- HOSPITAL INDEMNITY ONLY: This is a limited plan of Hospital Indemnity insurance. It is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.
- LIFE ONLY: I understand that life insurance coverage for a dependent/family member, other than a newborn child, will not take effect if that dependent/family member 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.
- 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 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, 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.

SIGNATURE OF EMPLOYEE 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: 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: 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 benefit.

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.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits subject to the conditions/provisions of the policy.

Oregon: 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 thereto, may be committing a fraudulent act, and may be subject to civil penalties or dental of insurance benefits.

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.

Oklahoma: WARNING: Any person who knowingly, and with the 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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.

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.

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.