GUARDIAN®

The Guardian Life Insurance Company of America

☐ The Guardian Life Insurance Company of America underwrites group term life, short term disability, long term disability, dental, and vision coverages.

Enrollment Form

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

Please print clearly and mark carefully.

Employer Name: **Volunteers of America Chesapeake**	Group Plan Number: **00514207**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment ☐ Re-Enrollment ☐ Add Employee/Dependents ☐ Drop/Refuse Coverage ☐ Information Change ☐ Increase Amount ☐ Family Status Change

Class: All Other Eligible Employees Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:

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? The term spouse includes your 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: ___-___-___	Annual Salary: $_____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. Additional information may be required for non-standard dependents such as a niece or a nephew.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender ☐ M ☐ F	Social Security Number ___-___-___ Date of Birth (mm-dd-yyyy) ___-___-___	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐ M ☐ F	Social Security Number ___-___-___ Date of Birth (mm-dd-yyyy) ___-___-___	Status (check all that apply) ☐ Disabled ☐ Non standard dependent (Niece or Nephew)
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐ M ☐ F	Social Security Number ___-___-___ Date of Birth (mm-dd-yyyy) ___-___-___	Status (check all that apply) ☐ Disabled ☐ Non standard dependent (Niece or Nephew)

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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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) ❑ Disabled ❑ Non standard dependent (Niece or Nephew)
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) ❑ Disabled ❑ Non standard dependent (Niece or Nephew)

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

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: Value	❑	❑	❑	❑
Option 2: 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	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature - Designer	❑	❑	❑	❑

❑ 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
☑ 100% of your annual salary to a maximum of $300,000
The Guarantee Issue Amount is $300,000.

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.

LIFE INSURANCE *continued*

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 Amount*

❑ 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					

**Guarantee Issue Amount*

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

❑ I do not want this coverage

***Add* Voluntary Life for Dependent/Child(ren)**

Policy Amount

❑ $1,000	❑ $2,000	❑ $3,000	❑ $4,000	❑ $5,000	❑ $6,000
❑ $7,000	❑ $8,000	❑ $9,000	❑ **$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 for Voluntary Life.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.

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.)

Short-Term Disability (STD) Coverage:

Weekly Benefit

☑ 60% of salary to a maximum of $750

Long-Term Disability (LTD) Coverage:

Monthly Benefit

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

Signature

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