Please print clearly to ensure accurate processing

Group Enrollment/Change Form

GUARDIAN®

Employer:
Wyandanch Union Free School District
1445 Straight Path
Wyandanch, NY 11798

Guardian Group Plan Number: **473131**

The Guardian Life Insurance Company of America
The Guardian Life Insurance Company of America underwrites all coverages except Guardian Universal Life (GUL) insurance.

EMPLOYER USE ONLY New Application Add Dependent(s) Drop Dependent(s) Change Address Change Name Drop Coverage as of: / /			
Class **Eligibles**	Hours Worked	Division	Benefits Effective / /
Keep a copy for your records and return form to: **Northeast Regional Office, P.O. Box 26040, Lehigh Valley, PA 18002-6040**			

ABOUT YOURSELF

Print clearly in black or blue ink.

First, Middle Initial, Last Name Add Change Drop	Sex M F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -
Address	City	State	Zip
Preferred E-mail	Day Phone	Eve Phone	The best way to reach you: E-mail Day Phone Eve Phone
Job Title	Work Status Full-Time Part-Time Retired COBRA/State Continuation	Date work status began / /	
Are you married? Yes No	Do you have children or other dependents? Yes No		

ABOUT YOUR DEPENDENTS

A sheet with information about additional dependents is attached.

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

To drop coverage for yourself or your dependents, check the box(es) to the right 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 coverages.
Vision

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Nov 23, 2011

CHOOSE YOUR VISION COVERAGE			*Check one box only*
	Full Feature - Designer		
Employee alone			I waive this coverage
Entire family			I waive this coverage
If you are waiving coverage, are you covered under another vision plan? Yes No	If you are waiving dependent coverage, are your dependents covered under another vision plan? Yes No		

IMPORTANT NOTES

Proof of insurability does not apply to vision, but if you waive vision coverage and later decide to enroll, you may be subject to delays in enrollment.
Your plan includes a One Year Lock-In/Lock-Out Provision - Your election to enroll in or waive vision coverage must remain in effect until your plan's next annual vision enrollment period.

SIGNATURE

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 understand that my dependent(s) cannot be enrolled for coverage if I am not enrolled for that coverage. I further understand that: (1) if a National Medical Support Notice (NMSN) has been issued for my dependent child(ren) pursuant to state or federal law, Guardian is required to enroll such dependent child(ren) for the coverage required by the NMSN, and , if necessary, to enroll me for that coverage, regardless of whether or not the enrollment form has been signed; and (2) late entrant penalties and enrollment period restrictions do not apply to such enrollments.
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 state that the information provided above is true and correct to the best of my knowledge and belief. Any person 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 civil penalty not to exceed five thousand dollars and stated value of the claim for each such violation (does not apply to life insurance).

SIGNATURE OF EMPLOYEE X _____ **DATE** _____