ARCHDIOCESE OF NEW ORLEANS

ENROLLMENT FORM

Guardian Group ID #s 538205 (Voluntary Life, Dental & Vision)
538250 (Basic Life, STD & LTD)

Human Resource Use	Type of Enrollment: ❑ Change ❑ New Hire ❑ Annual Open Enrollment ❑ Late Entrant	Location/Division Code	Location Name:	Date of Hire:
			Sample Location	1/1/2016

❑ Is this Enrollment Due to a Qualifying Life Event (Event examples: Marriage, Birth, Adoption, Divorce) Event: _____	Date of Life Event:	Employee Phone # ❑ Cell ❑ Home	Employee Email Address:
		504-123-4567	ARCHDIOCESE@AOL.COM

Employee Name:	Employee Date of Birth:	Employee Social Security #:	Marital Status:	Date of Marriage: (if applicable)	Employee Gender:
John Doe	1/1/1970	123-45-6789	SINGLE		MALE

Address:	SS#	City:	State:	Zip:
123 ARCHDIOCESE DR.	123-45-6789	NEW ORLEANS	LA	70125
Spouse Name	SS#	Spouse Date of Birth	Spouse Gender	
Child Name	SS#	Child Date of Birth	Child Gender	Full-Time Student? (Y or N)
Child Name	SS#	Child Date of Birth	Child Gender	Full-Time Student? (Y or N)
Child Name	SS#	Child Date of Birth	Child Gender	Full-Time Student? (Y or N)
Child Name	SS#	Child Date of Birth	Child Gender	Full-Time Student? (Y or N)
Child Name	SS#	Child Date of Birth	Child Gender	Full-Time Student? (Y or N)
Child Name	SS#	Child Date of Birth	Child Gender	Full-Time Student? (Y or N)

BASIC LIFE/AD&D PLAN with Guardian Policy 538250

BASIC LIFE/AD&D PLAN: Your employer provides you with the following life insurance coverage at no cost to you.

☑ Your employer provides Basic Term Life and AD&D Coverage in the amount of 2.5 times your base annual earnings, up to a maximum of $200,000.

DISABILITY COVERAGE: Guardian Policy 538250

DISABILITY COVERAGE: Your employer provides you with the following disability insurance at no cost to you:

☑ Short Term Disability (STD) Coverage: 60% of your salary to a maximum of $1,000 per week

☑ Long Term Disability (LTD) Coverage: 60% of your salary to a maximum of $4,000 per month

EMPLOYEE VOLUNTARY LIFE and VOLUNTARY AD&D with Guardian Policy 538205

LIFE: You may elect additional Life Insurance for yourself and your dependents.

You may elect coverage for yourself in one of the following amounts:

❑ $25,000 ❑ $50,000 ❑ $75,000 ❑ $100,000 ❑ $150,000

You must be covered for Voluntary Life coverage in order to purchase coverage for your spouse and/or child(ren).

- You may elect coverage for your spouse in the amount of $25,000.
- You may elect coverage for your child(ren) in the amount of $10,000.

Monthly rates and premiums are based on your age on January 1st each year.

Your child(ren) are covered for voluntary life to their 26th birthday.

During your initial eligibility period (new hires), you may elect up to the Guarantee Issue Limit of $150,000 without completing EOI (Evidence of Insurability). If you decline coverage when it is initially offered to you, you will be required to complete EOI and you may be declined for coverage.

Qualifying Events: you may elect either Spouse or Child(ren) coverage without completing EOI on the occurrence of marriage, birth or adoption.

❑ No change to current election

❑ I want to elect **Employee Coverage** in the amount of $150,000

❑ I want to elect **Spouse Coverage** in the amount of $25,000

❑ I want to elect **Child Coverage** in the amount of $10,000

❑ I decline coverage (EOI will be required in the future)

Your request will not be effective until you receive carrier approval.

New Hires: You are eligible to enroll within 30 days of your Date of Hire.

Existing Employees: You will be eligible to enroll or make changes at the next scheduled Open Enrollment for Voluntary Life, held during May 2019 and effective on July1, 2019.

Employee Authorization Signature Required on Page 2 of this Enrollment Form.

DENTAL with Guardian Policy 538205

PPO DENTAL: You may elect coverage for yourself and your dependents.

Your dental plan uses Guardian's DentalGuard Preferred PPO Network.

Find a Provider Near You at www.GuardianAnytime.com and click on 'Find a Provider'.

Low Plan:

$50 Deductible, $1,250 Annual Maximum

Preventive:	Covered at 100%
Basic :	Covered at 80%
Major:	Not Covered
Ortho:	Not Covered

High Plan:

$50 Deductible, $1,250 Annual Maximum

Preventive:	Covered at 100%
Basic :	Covered at 80%
Major:	Covered at 50% after 6 months
Ortho:	Covered at 50% after 12 months

❑ No change to current election

I want to elect Dental coverage:

❑ Low Plan ❑ High Plan

❑ I want to elect Employee Only Dental coverage.

❑ I want to elect Dental coverage for Employee + 1 Dependent

❑ I want to elect Dental coverage for Employee + 2 or More Dependents

❑ I decline Dental coverage for this Plan Year.

VISION with Guardian Policy 538205

VISION: You may elect coverage for yourself and your dependents.

Your vision plan uses the VSP Signature Network.

Find a Provider Near You at www.GuardianAnytime.com and click on 'Find a Provider'.

❑ No change to current election

❑ I want to elect Employee Only Vision coverage.

❑ I want to elect Employee + Spouse Vision coverage

❑ I want to elect Employee + Child(ren) Vision coverage

❑ I decline Vision coverage for this Plan Year.

EMPLOYEE AUTHORIZATION

I verify that this enrollment form reflects my benefit elections under this plan. I have read the enrollment materials provided to me. I authorize my employer to deduct from my wages or salary any required premium contribution on a post-tax basis (Voluntary Life/Disability) as stipulated by this plan and my elections. I understand that my election will be effective through the end of the Plan Year and that I may not change my elections unless I experience a qualified change in status (as noted in the enrollment materials). If I experience a change in status, I must notify Human Resources and request to change my election within 30 days of the event, or I must wait until the next open enrollment period to change my election.

Life/Disability Disclaimer: 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 further understand that if I am not in active service on the date my coverage would otherwise take effect, I will be covered on the date I return to active service.

This disability plan includes a Pre-Existing Condition Limitation. Please refer to your certificate of coverage booklet for complete details regarding this provisions and all other provisions.

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, you may have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.

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.

Truth & Knowledge Disclaimer: I attest that the information provided above is true and correct to the best of my knowledge.

Fraud Statement: 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 hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

Required Signature/Date:

Name: _____ **Date:** _____