



In alliance with



The Guardian Life Insurance Company of America
Employee Enrollment Form
2-50 Employees Enrolling

- New Member
- Add Dependents
- Change in Plan

IMPORTANT NOTICE

The health service benefits provided by this plan are guaranteed by a policy issued by Guardian. Administrative services, such as billing and collection, customer service, claims payment and other related functions, including the preparation of employee certificates of insurance, and changes to such certificates are supplied by Destiny Health on behalf of Guardian.

SECTION A – GROUP DETAILS	
Company Name	Group #

SECTION B – GENERAL EMPLOYEE INFORMATION (Please print in blue or black ink)				
Employee's last name, first name, middle initial			Social Security Number	
Street number and street name				Apt. No.
City		State	Zip code	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (MM-DD-YYYY)	Spoken Language	Language Preference for Written Correspondence: (check one) <input type="checkbox"/> English <input type="checkbox"/> Spanish
Area code/home phone number	Area code/work phone number	Area code/fax number	E-mail address	
Date of full-time employment (MM-DD-YYYY)	Job position	Office Location	Hours worked per week for this employer	
If you are on COBRA or State Continuation, with this employer please indicate		<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation	Effective date	Termination date

SECTION C - REFUSAL OF COVERAGE: Please complete only if refusing coverage.				
This is to certify that I have been given the opportunity to apply for group health coverage under the mentioned group number issued by Guardian. I understand the coverage available and I refuse coverage. All eligible Employees and their dependents must be listed as either enrolling or declining coverage when first eligible. If you or your eligible dependents do not enroll in the Guardian Plan when coverage is first made available and want to enroll in the future, coverage may be postponed and/or a preexisting condition exclusion may apply for up to 18 months. (Such exclusion would not apply to maternity benefits.) For more information, contact Guardian/Destiny Health.				
I refuse coverage for: <input type="checkbox"/> myself <input type="checkbox"/> my spouse <input type="checkbox"/> my child(ren)				
Reasons for refusing coverage:		<input type="checkbox"/> individual coverage	<input type="checkbox"/> COBRA or state continuation	<input type="checkbox"/> retiring
		<input type="checkbox"/> covered under spouse	<input type="checkbox"/> government coverage	<input type="checkbox"/> other:
Employee's signature			Date	

IF YOU HAVE REFUSED COVERAGE, YOU NEED NOT COMPLETE ANY FURTHER SECTIONS OF THIS ENROLLMENT FORM.

SECTION D - COVERAGE DETAILS
Coverage is for (check all that apply): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) ____ (indicate number of child(ren) to be covered)

SECTION E – PROOF OF PRIOR COVERAGE
Did you or your dependent(s) have major medical coverage with any other carrier(s) within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please attach Certificates of Creditable Coverage from all insurance companies that you have had coverage with for the past 12 months.

SECTION F – COORDINATION OF BENEFITS
Are you or any of your dependents covered under any other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
To coordinate claim payment with other health plans, we need information concerning employment and any other health coverage that may be available to your spouse or dependents. We require a yearly update of this information. Payment of your claims may be delayed without current information.

SECTION G – DEPENDENT INFORMATION: Please list your spouse and eligible child(ren) to be covered

Only list last names for dependents with a <i>different</i> last name than Employee.	Social Security Number	Date of birth (MM-DD-YYYY)	Sex (M/F)	Relationship to you *	* Use the following codes C=natural/adopted child F=foster child X=stepchild H=handicapped child S=legally married spouse G=grandchild L=you are legal-guardian of child
Spouse's last name, first name, middle initial					
Full name(s) of child(ren) Last, first, middle initial					
1.					
2.					
3.					
4.					

- Do you have legal custody of each child to be covered? Yes No If no, please comment in the space below
- Is each child to be covered *unmarried*? Yes No If no, please comment in the space below
- Does each child to be covered receive principal support from you? Yes No If no, please comment in the space below
- Does each child to be covered live with you? Yes No If no, please comment in the space below
- Is any child to be covered a Full-time Student age 19 or over? Yes No If yes, please complete Student Status section below

Use this space to comment or provide any other information you feel is pertinent.

Student Status: Complete for each Dependent child who is a Full-time Student age 19 or over.

Student name	Semester Starts	Semester Ends	Expected graduation year	School name	School City and State	School phone number

SECTION H – ACKNOWLEDGEMENT, CONSENT, AND SIGNATURE

- I certify that the information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the Group Policy.
- I apply for myself and any dependents detailed above to join the Guardian Plan and agree to adhere to and familiarize myself with the terms of coverage set forth in the Certificate and any amendments, riders, or other materials.
- I have read, or had read to me, and understand the questions and responses and realize any false statements, omissions and/or intentional material misrepresentation could cause coverage, if issued, to be cancelled as never effective. **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.
- I authorize Group to make deductions from my earnings for my share of the cost, if any, for the benefits to which I may become entitled.
- I authorize Guardian/Destiny Health to administer my Personal Medical Fund in accordance with the PMF administration materials.
- I acknowledge that the coverage under the Guardian Plan provides the benefits mandated by Texas.
- Upon termination of my membership from the Guardian Plan, I shall repay any amount by which claims were paid by the Personal Medical Fund that exceed cumulative contributions.
- I authorize Guardian to use my social security number when required in connection with treatment, payment, and healthcare operations.
- Consent to Release Medical Information.** I give my consent for any Medical Professional, hospital, clinic, laboratory, other medical or medically related facility, governmental agency, the Medical Information Bureau or other person or firm to provide The Guardian Life Insurance Company of America ("Guardian"), or their authorized representatives, any information regarding my medical history, including copies of records, and medical, radiological and laboratory testing results, concerning advice, care or treatment provided to me and/or my dependent(s), including without limitation, information relating to mental illness or use of drugs or alcohol. I understand that Guardian or Guardian representatives will use any information released under this consent solely for the purposes of their health care operations or for paying, determining, or administering claims for insurance benefits of me or my dependent(s). I understand that I or any authorized representative will receive a copy of this consent upon request. This consent is valid [from the date signed through the terms of coverage.] A photocopy of this consent shall be considered as effective and valid as the original.
- I acknowledge receiving the Notice to Employees – "HIPAA" Applicable to Your Group Coverage and the Notice Regarding the Medical Information Bureau.

Employee's signature	Today's Date
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Company Name _____	Account # _____
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	Name (Last, First, Middle Initial)	Height	Weight	Used tobacco in the last 12 months?
Employee		___ft. ___in.	___ lbs.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse (only if enrolling)		___ft. ___in.	___ lbs.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide the following information for **ALL** individuals (Employee, spouse and child(ren)) for whom coverage is being requested. **Please provide details to ALL "yes" answers. If more space is needed, attach a separate page. Sign and date each page.**

1. Is any individual currently pregnant? Yes No Who? _____ **Multiple fetuses?** Yes, Number ___ No
Due Date: ___/___/___ **Complications** (current or past)? Yes No Details if yes: _____
2. Has any individual ever been diagnosed with or treated for HIV, AIDS or AIDS-Related Complex? Yes No
3. In the past 24 months, has any individual been advised to have treatment or been treated for drug abuse, chemical dependency or alcohol abuse? Yes No
4. In the past 24 months, has any individual been diagnosed with, treated for, or is any individual currently suffering from any of the following:
 - a. Heart Disease, Stroke, High Blood Pressure, Elevated Cholesterol, Heart Murmur, Varicose Veins Yes No
 - b. Asthma, COPD, Respiratory Disease, Sleep Apnea, Migraines, Epilepsy, Paralysis, Cerebral Palsy, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS) Yes No
 - c. Depression, Anxiety, ADD/ADHD, Bipolar Disorder, Schizophrenia, Brain or Spinal Cord Injuries Yes No
 - d. Cancer, Tumor, Lumps, Growths, Kidney Disease, Kidney Failure Yes No
 - e. Diabetes, Hepatitis, Liver Disease, Hyperthyroidism, Lupus (Systemic or Discoid), Blood or Bleeding Disorders Yes No
 - f. Prostate Disorder, Infertility, Endometriosis, Ulcerative Colitis, Crohn's Disease Yes No
 - g. Arthritis (osteo or rheumatoid), Herniated disc, Torn ACL/meniscus of knee Yes No
 - h. Any condition requiring or potentially requiring an organ transplant Yes No
 - i. Any symptom or condition requiring hospitalization, surgery or diagnostic testing, or is any individual currently taking any prescription medications? Yes No

Family Member	Diagnosis and Date Diagnosed (MM / YYYY)	Treatment Date(s) (past or planned)	Treatment received, medications taken, type of testing or surgery planned or performed	Current treatment?	Recovered?
		_____ to _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		_____ to _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		_____ to _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		_____ to _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		_____ to _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If more space is needed, attach a separate page. Sign and date each page.

I certify that the information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. This form and any attachments are a part of this request for coverage under the Group Policy.

Employee's Signature _____

Today's Date _____