GUARDIAN® In alliance with Destiny Health™

The Guardian Life Insurance Company of America
Employee Enrollment Form
51+ Eligible Employees 51 or more 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.

Destiny Health is located at: 1211 West 22nd Street, Suite 221
Oak Brook, Illinois 60523
Tel (866) 826-2344
www.glic-destiny.com

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: ☐ Single ☐ Married ☐ Divorced	Gender: ☐ Male ☐ Female	Date of birth (MM-DD-YYYY)	Spoken language
Area code/home phone number	Area code/work phone number	Area code/fax number	E-mail address
Date of employment (MM-DD-YYYY)	Job position	Office Location	Hours worked per week for this employer
If you are on COBRA or State Continuation, please indicate	☐ COBRA ☐ 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 Destiny Health.

I refuse coverage for: ☐ myself ☐ my spouse ☐ my child(ren)

Reasons for refusing coverage:	☐ individual coverage	☐ COBRA or state continuation	☐ retiring
	☐ covered under spouse	☐ government coverage	☐ 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): ☐ Self ☐ Spouse ☐ 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? ☐ Yes ☐ 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

PLEASE RETURN THIS FORM TO YOUR EMPLOYER

Are you or any of your dependents covered under any other health coverage? ☐ Yes ☐ 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 *different* last name than Employee.	Social Security Number	Date of birth (MM-DD-YYYY)	Sex (M/F)	Relationship to you *	
Spouse's last name, first name, middle initial					
Full name(s) of child(ren) Last, first, middle initial					* Use the following codes C=natural/adopted child F=foster child X=stepchild H=handicapped child S=legally married spouse
1.					
2.					
3.					
4.					

1.	Do you have legal custody of each child to be covered?	☐ Yes ☐ No	If no, please comment in the space below
2.	Is each child to be covered *unmarried*?	☐ Yes ☐ No	If no, please comment in the space below
3.	Does each child to be covered receive principal support from you?	☐ Yes ☐ No	If no, please comment in the space below
4.	Does each child to be covered live with you?	☐ Yes ☐ No	If no, please comment in the space below
5.	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

1. 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.
2. 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.
3. I have read, or had read to me, and understand the questions and responses and realize any false statements; omissions and/or material misrepresentation could cause coverage, if issued, to be cancelled as never effective. Any person, who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
4. 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.
5. I authorize [Guardian/Destiny Health] to administer my Personal Medical Fund in accordance with the PMF administration materials.
6. I acknowledge that the coverage under the Guardian plan provides the benefits mandated by the State of Illinois.
7. 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.
8. I authorize Guardian to use my social security number when required in connection with treatment, payment, and healthcare operations.
9. Consent to Release Medical Information. I give my consent for any Medical Professional, hospital, clinic, laboratory, other medical or medically related facility, governmental agency, 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.

Employee's signature	Today's Date

PLEASE RETURN THIS FORM TO YOUR EMPLOYER

Statement of Health
51+ Enrolled Employees

Company Name	Account #

	Name (Last, First, Middle Initial)	Height	Weight	Used tobacco in the last 12 months?
Employee		___ft. ___in.	_____ lbs.	☐ Yes ☐ No
Spouse		___ft. ___in.	_____ lbs.	☐ Yes ☐ 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? _____
   Due Date: ____/____/_____ Multiple fetuses? ☐ Yes, Number ___ ☐ No
   Complications (current or past)? ☐ Yes ☐ No Details if yes:_____

2. Are you or any of your dependents suffering from a chronic illness or developmental birth defect, or are you or any of your dependents disabled (i.e. unable to perform normal duties)? ☐ Yes ☐ No

   Examples of the types of conditions that should result in a "yes" answer include but are not limited to: heart disease or stroke, emphysema or respiratory disorder, kidney or pancreatic disease, diabetes, hepatitis or other liver disease, cancer, HIV, AIDS or AIDS-related complex.

Who?	Diagnosis	Date diagnosed	Treatment Date(s)	Treatment received, medications taken, surgery performed
		____/____/_____	____/____/_____	
		____/____/_____	____/____/_____	
		____/____/_____	____/____/_____	

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

3. In the past 12 months, has any individual applying for coverage been or been advised to be hospitalized, had or been advised to have surgery or diagnostic testing, or is any individual currently taking any prescription medications? ☐ Yes ☐ No

Who?	Diagnosis	Date diagnosed	Treatment Date (past or planned)	Treatment received, medications taken, surgery performed	Recovered?
		____/____/_____	____/____/_____		☐ Yes ☐ No
		____/____/_____	____/____/_____		☐ Yes ☐ No
		____/____/_____	____/____/_____		☐ Yes ☐ 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