



THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

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

Please print clearly and mark carefully.

Employer Name: NORTH COUNTRY CHAMBER OF COMMERCE	Group Plan Number: 00528012	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX	Initial Enrollment	Add Employee/Dependents
	Drop/Refuse Coverage	Information Change

Class: a Division: _____ Subtotal Code: _____ (Please obtain this from your Employer)

About You: First, MI, Last Name: _____	Employer Provided Identification: _____	Social Security Number or Taxpayer Identification Number (TIN) ____ - ____ - ____ <small>Your Social Security Number or TIN must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.</small>	
Address _____	City _____	State _____	Zip _____
Gender: M F	Date of Birth (mm-dd-yy): ____ - ____ - ____		
Phone (indicate primary): Home (____) ____ - ____ Work (____) ____ - ____ Mobile (____) ____ - ____			
Email Address (indicate primary) Home _____ Work _____			
		Are you married or do you have a partner? Yes No	Date of marriage/union: ____ - ____ - ____
		Do you have children or other dependents? Yes No	Placement date of adopted child: ____ - ____ - ____

About Your Job:	Job Title: _____		
Work Status: Active Retired Cobra/State Continuation	Date of full time hire: ____ - ____ - ____		
Hours worked per week: _____			

About Your Family: Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Your dependent's Social Security Number or TIN must be provided if enrolling for Life Coverage. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (wherever the term "Spouse" appears on this form, it also includes "Partner"). Address/City/State/Zip: _____ Phone: () - _____	Gender M F	Social Security Number or TIN ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: _____ Phone: () - _____	Add Drop Gender M F	Social Security Number or TIN ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

Child/Dependent 2: Address/City/State/Zip: Phone: () -	Add Drop	Gender M F	Social Security Number or TIN ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: () -	Add Drop	Gender M F	Social Security Number or TIN ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () -	Add Drop	Gender M F	Social Security Number or TIN ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

<p>Drop Coverage: Drop Employee Drop Dependents The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: ____ - ____ - ____ Termination of Employment Retirement Last Day Worked: ____ - ____ - ____ Other Event: _____ Date of Event: ____ - ____ - ____</p>	<p>Coverage Being Dropped: Dental Employee Spouse Child(ren)</p>
<p>Loss Of Other Coverage: I and/or my dependents were previously covered under Loss of coverage was due to: Termination of Employment: ____ - ____ - ____ Divorce/Separation ____ - ____ - ____ Death of Spouse ____ - ____ - ____ Termination/Expiration of Coverage ____ - ____ - ____ Coverage Lost Dental</p>	<p>I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: Covered under another insurance plan Other _____ (additional information may be required)</p>

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

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
PPO*	\$38.23	\$77.62	\$104.10	\$153.61

*Monthly Rate (includes Pediatric Essential Health Benefit)

I do not want Dental Coverage because (Check 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

Signature

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

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 if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.

I understand that my coverage will not be effective until approved by 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 agree that my [employer] or my employer's designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.

By my signature below, I affirmatively consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice

By my signature below, I affirmatively 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 state that the information provided above is true and correct to the best of my knowledge and belief.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: Any person who 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____

DATE _____

Enrollment Kit 00528012, 0003, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly 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 subject to the conditions/provisions of the policy.

Oregon: 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 thereto, may be committing a fraudulent act, and may be subject to civil penalties or denial of insurance benefits.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who 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 subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.