GUARDIAN™

Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Fax: 509-468-6595

Custom Group Insurance Enrollment and Record Form

Check reason for completing form:

☐ New Subscriber ☐ Delete Coverage ☐ Add a Family Member
☐ Change Address ☐ Change Name ☐ Terminate a Family Member
Date of Change _____ Reason for Change _____

PLANHOLDER NAME (EMPLOYER NAME)	GROUP PLAN NO.	DIVISION
U Save Pharmacy		

PLANHOLDER STREET ADDRESS	CITY	STATE	ZIP

EMPLOYEE'S NAME (LAST, FIRST, MI)	SOC. SEC. NO.	BIRTHDATE	SEX

EMPLOYEE'S MAILING ADDRESS	CITY	STATE	ZIP

	CLASS	DATE OF FULL TIME EMPLOYMENT	HRS. WK.	

MARITAL STATUS
☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

DEPENDENT CHILDREN
☐ Yes ☐ No

COVERAGE ELECTION

Dental:
EMPLOYEE: ☐ I elect coverage SPOUSE: ☐ Yes ☐ No** CHILD(REN): ☐ Yes ☐ No**

☐ I decline coverage. * I understand if I elect coverage at a later date, late entrant penalties will apply.
*** If declining coverage, are you covered under another dental plan?** ☐ **Yes** ☐ **No**
**** If declining dependent coverage, are your dependents covered under another dental plan?** ☐ **Yes** ☐ **No**

Basic Life Coverage of $20,000: ☐ **I elect coverage** ☐ **I decline coverage*****

Voluntary Term Life:

In the last 6 months, have you or any of your dependents received medical treatment, consultation, care or services, including diagnostic measures or took prescribed drugs for: cardiovascular disease; cancer; any condition related to Acquired Immune Deficiency Syndrome (AIDS) or Related Complex; or any other life threatening condition? **Employee** ☐ **Yes** ☐ **NO** Spouse ☐ Yes ☐NO **Child(ren)** ☐ Yes ☐ No
AN EVIDENCE OF INSURABILITY FORM(S) MUST BE COMPLETED FOR ANY EMPLOYEE OR DEPENDENT(S) WITH A "YES" ANSWER TO THE ABOVE QUESTION

EMPLOYEE:
☐ $ 25,000
☐ $ 50,000
☐ $ 75,000
☐ $100,000
☐ I decline coverage*** (This also waives ALL dependent coverage)

SPOUSE:
☐ Yes ☐ No (Flat $10,000)
or
☐ Yes ☐ No (50% of emp amt to $50,000)

CHILD(REN) (10% of emp amt to $10,000)
☐ Yes ☐ No
(Less than 14 days is not covered)
(14 days to 6 months is limited to a $500 benefit)

*** If I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense proof of each person's insurability, and Guardian reserves the right to reject my request.

Give the following information for each dependent to be insured:

NAME (Last, First, Middle Initial)	SEX	RELATIONSHIP	BIRTHDATE	STUDENT
Spouse	☐ F ☐ M			☐ Yes ☐ No
Child	☐ F ☐ M			☐ Yes ☐ No
Child	☐ F ☐ M			☐ Yes ☐ No
Child	☐ F ☐ M			☐ Yes ☐ No

EMPLOYEE BENEFICIARY DESIGNATION	(Include full proper name and relationship; i.e.: John M. Doe, husband)
Name:	Relationship:

I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for insurance, or agree that the contributions be added to my dues; (3) state that I became an employee on the date stated above, and do currently work the number of hours per week stated above; (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death; and know my coverage will not take effect unless I am actively at work and life insurance coverage for my dependents will not take effect if a dependent, other than a newborn, is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex.

Any person who, with intent to defraud of knowing that he 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.

I have reviewed the statements on this application and they are true and complete.

SIGNATURE OF EMPLOYEE:	**DATE:**