

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

Please print clearly and mark carefully.

Employer Name: T ROSS BROTHERS CONSTRUCTION INC	Group Plan Number: 00518928	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Re-Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		
<input type="checkbox"/> Increase Amount <input type="checkbox"/> Family Status Change		

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

About You: First, MI, Last Name:		Social Security Number _____ - _____ - _____	
Address	City	State	Zip
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy): _____ - _____ - _____	Phone: () - _____ - _____	
Email Address:	Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage/union: _____ - _____ - _____	
	Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placement date of adopted child: _____ - _____ - _____	

About Your Job:		Hours worked per week: _____	Job Title: _____
Work Status:	Date of full time hire: _____ - _____ - _____		
<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra/State Continuation			

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____	Date of Birth (mm-dd-yyyy) _____ - _____ - _____
Address/City/State/Zip: _____ Phone: () - _____ - _____			
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) _____ - _____ - _____
Phone: () - _____ - _____			
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number _____ - _____ - _____
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) _____ - _____ - _____
Phone: () - _____ - _____			
Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent			

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

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

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

Your Weekly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
PPO	<input type="checkbox"/> \$8.38	<input type="checkbox"/> \$17.00	<input type="checkbox"/> \$20.23	<input type="checkbox"/> \$30.68

I do not want this coverage. If you do not want this Dental Coverage, please mark 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

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

Your Weekly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature - Designer	<input type="checkbox"/> \$1.75	<input type="checkbox"/> \$3.32	<input type="checkbox"/> \$3.45	<input type="checkbox"/> \$5.14

I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:

I am covered under another Vision plan
 My spouse is covered under another Vision plan
 My dependents are covered under another Vision plan

Signature

- An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- 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, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- 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 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.
- I attest that the information provided above is true and correct to the best of my knowledge.

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

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 00518928, 0001, 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.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

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.