

Please print clearly to ensure accurate processing



Employer:
Diocese of Gary
9292 Broadway
Merrville, IN 46410

Guardian Group Plan Number: 376301

The Guardian Life Insurance Company of America

First Commonwealth Limited Health Services Corporation

EMPLOYER USE ONLY
New Application
Add Dependent(s)
Drop Dependent(s)
Change Address
Change Name
Drop Coverage as of: / /
Class: All Eligible Employees
Hours Worked
Division
Benefits Effective: / /
Keep a copy for your records and return form to: Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012

ABOUT YOURSELF
Print clearly in black or blue ink.
First, Middle Initial, Last Name
Sex: M F
Date of Birth (mm/dd/yyyy)
Social Security Number
Address
City
State
Zip
Preferred E-mail
Day Phone
Eve Phone
The best way to reach you:
E-mail
Day Phone
Eve Phone
Job Title
Work Status
Date work status began
Full-Time
Part-Time
Retired
COBRA/State Continuation
Are you married? Yes No
Do you have children or other dependents? Yes No

ABOUT YOUR DEPENDENTS
A sheet with information about additional dependents is attached.
Spouse First, Middle Initial, Last Name
Sex
Date of Birth (mm/dd/yyyy)
Social Security Number
Marriage Date
Child 1
Child 2
Child 3
Child 4
To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages.
Dental

CHOOSE YOUR DENTAL COVERAGE*Check one box only*

Your monthly premium	Option 1: DHMO	Option 2: PPO	
Employee alone _____	<input type="checkbox"/> \$15.00	<input type="checkbox"/> \$27.00	<input type="checkbox"/> I waive this coverage
Employee and 1 Dependent _____	<input type="checkbox"/> \$30.00	<input type="checkbox"/> \$53.00	<input type="checkbox"/> I waive this coverage
Entire family _____	<input type="checkbox"/> \$39.00	<input type="checkbox"/> \$81.00	<input type="checkbox"/> I waive this coverage

List dental office location number(s) (Pre-Paid Plan only)

Employee _____ Spouse/DP _____ Child(ren) _____

 A separate sheet with additional dental office numbers for dependents is attached.*If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.*Reason for Loss of coverage: Termination of Employment Divorce Death of Spouse

Date of coverage loss

 Termination or Expiration of coverage

/ /

If you are waiving coverage, are you covered under another dental plan?

 Yes No

If you are waiving dependent coverage, are your dependents covered under another dental plan?

 Yes No**IMPORTANT NOTES**

- Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.
- Late entrant penalties or proof of insurability do not apply to Pre-Paid dental coverage. The Pre-Paid dental plan refers to, as applicable, First Commonwealth Limited Health Services Corporation. Eligibility for this coverage is only available at the open enrollment period.

SIGNATURE

- 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 understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- I understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums

shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.

- I attest that the information provided above is true and correct to the best of my knowledge.
- 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 be guilty of insurance fraud.

SIGNATURE OF EMPLOYEE X**DATE**