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

Please print clearly and mark carefully.

Employer Name: **TRI-COUNTY COMMUNITY ACTION AGENCY, INC.**	Group Plan Number: **00524724**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change

Class: ALL ELIGIBLE EMPLOYEES Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:

First, MI, Last Name:

Employer Provided Identification:

_____

Social Security Number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.

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 Hours worked per week: _____	Date of full time hire: _____ - _____ - _____	Annual Salary: $_____

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 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 "Civil Union Partner".		Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Dependent/Child 1:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Dependent/Child 2:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Dependent/Child 3:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Dependent/Child 4:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Oct 10, 2022

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: _____-_____-_____

Coverage Being Dropped:

❑ Dental	❑ Employee	❑ Spouse	❑ DepChild(ren)
❑ Voluntary Life	❑ Employee	❑ Spouse	❑ DepChild(ren)
❑ Accident	❑ Employee	❑ Spouse	❑ DepChild(ren)

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

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)

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

	Employee Only	Employee and 1 Dependent	EE, Spouse & Dependent/Child(ren)
Option 1: HIGH PLAN	❑	❑	❑
Option 2: LOW PLAN	❑	❑	❑

❑ 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

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D): **You must be enrolled to cover your dependents.** ***Benefit reductions apply. Please see plan administrator.***

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

Employee

Policy Amount ***Check one box only***

❑ $10,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000	❑ $60,000
❑ $70,000	❑ $80,000	❑ $90,000	❑ $100,000	❑ $110,000	❑ $120,000
❑ $130,000	❑ $140,000	❑ $150,000	❑ $160,000	❑ $170,000	❑ $180,000
❑ $190,000	❑ **$200,000***	❑ $210,000	❑ $220,000	❑ $230,000	❑ $240,000
❑ $250,000	❑ $260,000	❑ $270,000	❑ $280,000	❑ $290,000	❑ $300,000
❑ $310,000	❑ $320,000	❑ $330,000	❑ $340,000	❑ $350,000	❑ $360,000
❑ $370,000	❑ $380,000	❑ $390,000	❑ $400,000	❑ $410,000	❑ $420,000
❑ $430,000	❑ $440,000	❑ $450,000	❑ $460,000	❑ $470,000	❑ $480,000
❑ $490,000	❑ $500,000				

*Guarantee Issue Amount. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

❑ I do not want this coverage

LIFE INSURANCE *continued*

***Add* Voluntary Life for Spouse**

Policy Amount

❑ $5,000	❑ **$10,000***	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000
❑ $35,000	❑ $40,000	❑ $45,000	❑ $50,000	❑ $55,000	❑ $60,000
❑ $65,000	❑ $70,000	❑ $75,000	❑ $80,000	❑ $85,000	❑ $90,000
❑ $95,000	❑ $100,000	❑ $105,000	❑ $110,000	❑ $115,000	❑ $120,000
❑ $125,000	❑ $130,000	❑ $135,000	❑ $140,000	❑ $145,000	❑ $150,000
❑ $155,000	❑ $160,000	❑ $165,000	❑ $170,000	❑ $175,000	❑ $180,000
❑ $185,000	❑ $190,000	❑ $195,000	❑ $200,000	❑ $205,000	❑ $210,000
❑ $215,000	❑ $220,000	❑ $225,000	❑ $230,000	❑ $235,000	❑ $240,000
❑ $245,000	❑ $250,000				

**Guarantee Issue Amount*

****The amount may not be more than 50% of the employee amount for Voluntary Life.***

❑ I do not want this coverage

***Add* Voluntary Life for Dependent/Child(ren)**

Policy Amount

❑ $1,000	❑ $2,000	❑ $3,000	❑ $4,000	❑ $5,000	❑ $6,000
❑ $7,000	❑ $8,000	❑ $9,000	❑ **$10,000***		

**Guarantee Issue Amount*

****The amount may not be more than 100% of the employee amount for Voluntary Life.***

❑ I do not want this coverage

Important Notes:

- **Based on your plan benefits and age, you may be required to complete an evidence of insurability form.**

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

Name your beneficiaries: (Primary beneficiary percentages must total 100%)
If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name:_____ **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Name:_____ **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Contingent Beneficiary:_____ **Social Security Number:** ___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Please contact your employer for any record of or changes to your beneficiary information.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ❑ Yes ❑ No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:
Name: _____ **Social Security Number (or FEIN/TIN # if a corporate entity):** ____ ____ ____ ____ ____-____ _____ ____
Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____
Phone: ( ) -

Accident Coverage

You must be enrolled to cover your dependents.

Your Bi-weekly premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
	❑ $4.87	❑ $8.38	❑ $8.84	❑ $12.35

❑ I do not want this coverage.

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records

Primary Beneficiaries:

Name:_____ **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Name:_____ **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Contingent Beneficiary:_____ **Social Security Number:** ___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

Please contact your employer for any record of or changes to your beneficiary information

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ❑ Yes ❑ No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ **Social Security Number (or FEIN/TIN # if a corporate entity):** ____ ____ ____ ____ ____-____ _____ ____
Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____
Phone: ( ) -

NOTICE: This coverage under the policy may only be issued if you have minimum essential coverage within the meaning of section 500A(f) of the Internal Revenue Code.

Signature

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- LIFE ONLY: I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that the contribution 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 enrollment materials.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as set forth ed in the enrollment matrials)This does not apply to eligible retirees.
- 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 understand that plan design limitations and exclusions may apply. All coverage is subject to the terms and conditions of the Guardian group policy. State limitations may apply.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

- I agree that my [employer] or my employer's designated administrator may deduct contributions from my pay apply contributions to my credit card or debit card, add contributions to my dues withdraw contributions from my designated bank account, apply contributions to my credit or debit card, if they are required for the coverage I have chosen.
- I acknowledge and consent to receiving electronic copies of Guardian applicable coverage 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 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.
- **I attest that the information provided above is true and correct to the best of my knowledge.**

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

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

The following section applies to these coverage(s): Accident Coverage, Cancer Coverage, Critical Illness Coverage and or Hospital Indemnity Coverage:

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.
IF YOU HAVE ENROLLED FOR ACCIDENT, CANCER, CRITICAL ILLNESS AND/OR HOSPITAL INDEMNITY COVERAGE, BY YOUR SIGNATURE BELOW, YOU ATTEST THAT YOU, AND ANY DEPENDENTS TO BE COVERED, HAVE MINIMUM ESSENTIAL COVERAGE WITHIN THE MEANING OF SECTION 500A(F) OF THE INTERNAL REVENUE CODE.

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

The requested activity is believed eligible and is approved by the Employer.

SIGNATURE OF EMPLOYER REPRESENTATIVE X _____ **DATE** _____

REPRESENTATIVE'S TITLE: _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form. These statements apply only to residents of the noted States:

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 dental 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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

INSTRUCTIONS

Employers - You must complete the Policyholder and Signature sections in order for this application to be processed.

Employees - You must complete all sections that apply to you and your dependents including the Signature section in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, select Disabled in Section E, and attach proof of disability.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.

CONDITIONS OF ENROLLMENT - EMPLOYEE ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Guardian, or any consumer reporting agency acting on behalf of Guardian, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Guardian has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Guardian will provide coverage in accordance with the terms of the contract for the group plan.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.