The Guardian Life Insurance Company of America
And its Affiliates and Subsidiaries

VISION ENROLLMENT FORM

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

Please print clearly and mark carefully.

Employer Name: University of Massachusetts Medical School	Group Plan Number: 00526237	Benefits Effective: _____

PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment ☐ Re-Enrollment ☐ Add Employee/Dependents ☐ Drop/Refuse Coverage ☐ Information Change ☐ Increase Amount ☐ Family Status Change

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

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

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 dependency tax exception. Dependency 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) Address/City/State/Zip: Phone: _____		Gender ☐ M ☐ F	Social Security Number _____ Date of Birth (mm-dd-yyyy) _____	
Child/Dependent 1: Address/City/State/Zip: Phone: _____	☐ Add ☐ Drop	Gender ☐ M ☐ F	Social Security Number _____ 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 _____ 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: Jul 29, 2016

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

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

Your Bi-Weekly Premium	Employee Only	EE, Spouse & Dependent/Child(ren)
Full Feature	☐ $2.94	☐ $8.10

☐ 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.
- Your coverage will not be effective until approved by a 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 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.
- "Caution: If you answers on this application are incorrect or untrue, Guardian has the right to deny benefits or rescind your policy."

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 hereto, 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 _____

When form is complete, click here to submit