

Guardian AccidentGuard Adv Late Enrollment Form

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Coverage for (Select one): Employee Only Employee/Spouse Employee/Child(ren) Family

Employee Information

Group Name		Hire Date* (MM/DD/YYYY)			
Prefix	First Name*	Middle Initial	Last Name*	Suffix	Social Security #*
Date of Birth* (MM/DD/YYYY) ____/____/____	Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Address*		Apt	City/State/Zip*		County
Home Phone	Cell Phone	Work Phone/Ext		Email Address*	

Dependent Demographics - Please include the names of the dependents you wish to enroll for coverage.

Dependent 1	Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY) ____/____/____	Social Security #*
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Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed
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Relationship*: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Domestic Partner Child
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Dependent 2	Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY) ____/____/____	Social Security #*
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Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed
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Relationship*: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Domestic Partner Child
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Dependent 3	Prefix	First Name*	Middle Initial	Last Name*	Date of Birth* (MM/DD/YYYY) ____/____/____	Social Security #*
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Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed
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Relationship*: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Domestic Partner Child
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Beneficiary

Beneficiary Name 1*	Relation*	Percent*
Beneficiary Name 2*	Relation*	Percent*

Signature

- 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 agree that my [employer] or my employers designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.
- I understand that this is a supplemental accident-only policy and that it does not provide coverage for and is not intended to replace comprehensive hospital, surgical and medical insurance. I understand that this policy does not provide coverage for sickness. I acknowledge that I have comprehensive hospital, surgical and medical insurance. If you have questions about the benefits provided by this coverage, please contact us at 888-313-7277

SIGNATURE OF EMPLOYEE

Date