



Employer:  
**Town of Burlington**  
 29 Center Street  
 Burlington, MA 01803

Guardian Group Plan Number: **452725**

The Guardian Life Insurance Company of America

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

<b>ABOUT YOURSELF</b> <small>Print clearly in black ink only</small>			
First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> E-mail <input type="checkbox"/> Day Phone <input type="checkbox"/> Eve Phone
Job Title	Work Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation	Date work status began / /	
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>ABOUT YOUR DEPENDENTS</b> <small>A sheet with information about additional dependents is attached.</small>					
Spouse First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Marriage Date / /	
Child 1 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
Child 2 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
Child 3 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
Child 4 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
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. <input type="checkbox"/> Dental					

<b>CHOOSE YOUR DENTAL COVERAGE</b> <small>Check one box only</small>			
Your monthly premium	PPO		
Employee alone	<input type="checkbox"/> \$26.55		<input type="checkbox"/> I waive this coverage
Entire family	<input type="checkbox"/> \$71.62		<input type="checkbox"/> I waive this coverage
If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.			
Reason for Loss of coverage: <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Spouse <input type="checkbox"/> Termination or Expiration of coverage			Date of coverage loss / /
If you are waiving coverage, are you covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you are waiving dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER**

## 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.
  - Vision Discount Access is included with your dental plan at no charge. You must elect dental in order to qualify for Vision Discount Access.
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## 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**

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DATE

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