



Employer:
Rochester Business Alliance
 150 State Street
 Rochester, NY 14614

Guardian Group Plan Number: **373984**
 Plan Administrator: **Nina Shelton**

The Guardian Life Insurance Company of America

EMPLOYER USE ONLY <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 / /
All Eligible Members			
Keep a copy for your records and return form to: Northeast Regional Office, P.O. Box 26040, Lehigh Valley, PA 18002-6040			

ABOUT YOURSELF <small>Print clearly in black or blue ink</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	

ABOUT YOUR DEPENDENTS <small>A sheet with information about additional dependents is attached</small>					
Spouse/DP 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 left 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					

CHOOSE YOUR DENTAL COVERAGE			
Employee alone	PPD <input type="checkbox"/>		<input type="checkbox"/> I waive this coverage
Entire family	<input type="checkbox"/>		<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/DP <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	

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/DP, divorce or where a court has ordered coverage be provided for an eligible spouse/DP or eligible children, provided you apply within 30 days.
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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 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 civil penalty not to exceed five thousand dollars and stated value of the claim for each such violation (does not apply to life insurance).

SIGNATURE OF EMPLOYEE **X**

DATE
