

Instructions

Employer

- Complete the Employer Group Information on the upper left of the form.
- **Section A - Type of Activity:** Check boxes indicating reason(s) for submitting application.
- Complete Section I - Employer Verification.
 - Employer must complete this section for all new enrollments, coverage changes and terminations.
 - Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee - Complete Sections B-H

Section B - Employee Information:

- Complete all information in order for your application to be processed.

Section C - Plan Option:

- Select only one option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- 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. If a dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health or Rx drug coverage, check off the "Yes" box(es) and complete Section F - Other/Previous Insurance.
- From the appropriate provider directory, locate the 6-digit office ID number for the primary care physician, (if applicable). Indicate office ID number selection(s) on the form.

Section E - Pre-Existing Conditions Statement:

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in group coverage in a group of 2 - 5 employees and by late entrants.

Section F - Other/Previous Insurance:

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section G - Dependent Information:

- Complete this section for all new enrollments or coverage changes.

Section H - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section I - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditions of Enrollment

Employee Acknowledgement and Agreements

On behalf of myself and the dependents listed on page one, I agree to or with the following:

1. a) I authorize the sources stated below to give to Guardian and/or Health Net, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Guardian and/or Health Net has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
c) I know that I have a right to receive a copy of the authorization if I request one.
d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Guardian group policy, coverage is provided by Guardian and/or Health Net in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Guardian and/or Health Net.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

Group Information - To be completed by Employer

Group Name _____ Group Number _____ Class _____

A. Type of Activity - To be completed by Employer. Refer to Instructions before completing this form. Print clearly.

1. Enrollment New Enrollee Effective Date ___/___/___ Date of Hire ___/___/___

2. Change - Check all that apply Date of Event Reason

| | | |
|---|-------------|-------|
| <input type="checkbox"/> Add Spouse | ___/___/___ | _____ |
| <input type="checkbox"/> Add Domestic Partner | ___/___/___ | _____ |
| <input type="checkbox"/> Add Dependent Child | ___/___/___ | _____ |
| <input type="checkbox"/> Name Change | ___/___/___ | _____ |
| <input type="checkbox"/> Change Plan | ___/___/___ | _____ |
| <input type="checkbox"/> Other | ___/___/___ | _____ |

3. Remove or Terminate - Check all that apply Effective Date Reason

| | | |
|--|-------------|-------|
| <input type="checkbox"/> Remove Spouse* | ___/___/___ | _____ |
| <input type="checkbox"/> Remove Domestic Partner* | ___/___/___ | _____ |
| <input type="checkbox"/> Remove Dependent Child* | ___/___/___ | _____ |
| <input type="checkbox"/> Employee Withdrawal/Termination | ___/___/___ | _____ |

NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage. *Please complete Add/Change/Remove and Name columns in Section D.

4. Continuation of Coverage, i.e. COBRA, State, total disability. Not all options are available or applicable. Contact Employer for available options.
 Coverage for: Employee Dependents Length of Continuation: 12 months 18 months 29 months 36 months total disability*
 Date of Loss of Coverage: ___/___/___ Date of Qualifying Event: ___/___/___ *Attach proof of total disability

B. Employee Information - Complete Sections B-H

Last name, First name, M.I. _____ Social Security Number _____ Home Telephone _____
 E-mail Address _____
 Home Address _____ Apt. No. _____ City, State _____ Zip Code _____
 Employer Name _____ Work Telephone _____
 Work Address _____ City, State _____ Zip Code _____
 Date of Employment: _____ Hours worked per week: _____

C. Plan Option - Your selection must be offered by your Employer.

Select Coverage(s) Medical Employee Only Employee/Spouse/Domestic Partner Employee/Child(ren) Entire Family
 Dental Employee Only Employee/Spouse/Domestic Partner Employee/Child(ren) Entire Family
 Vision Employee Only Employee/Spouse/Domestic Partner Employee/Child(ren) Entire Family
 Select Coverage Options: Choose only one option for each coverage. Medical Charter HMO Passport HMO Charter POS Passport POS PPO
 Dental Option 1 Option 2 Option 3

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time post-secondary student. Attach proof of disability.

| | (A)dd (C)hange (R)emove | Last Name, First Name, Middle Initial | Sex M F | Birthdate MM DD YYYY | Social Security Number | Other Health Coverage | Other Rx Drug Coverage | Primary Office ID Number | Previous Coverage Check if Yes |
|------------------|-------------------------------|---------------------------------------|------------|-------------------------|---------------------------|--------------------------|------------------------------|-----------------------------|--------------------------------------|
| Employee | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> |
| Spouse | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> |
| Domestic Partner | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> |
| Child | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> |
| Child | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> |
| Child | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> |

E. Pre-Existing Conditions Statement

Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes No 1. During the past 6 months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes", check appropriate box(es) below.

- | | | | |
|--------------------------|--------------------------|---|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> a. Alcoholism or Drug Abuse | <input type="checkbox"/> h. Heart Disorder or Condition or Chest Pain |
| | | <input type="checkbox"/> b. Arthritis | <input type="checkbox"/> i. High Blood Pressure |
| | | <input type="checkbox"/> c. Blood Disorder | <input type="checkbox"/> j. Kidney or Liver Disorder |
| | | <input type="checkbox"/> d. Back or Neck Disorder, Injury or Pain | <input type="checkbox"/> k. Lung or Respiratory Disorder |
| | | <input type="checkbox"/> e. Cancer or Tumors | <input type="checkbox"/> l. Mental or Nervous Disorder |
| | | <input type="checkbox"/> f. Diabetes | <input type="checkbox"/> m. Paralysis, Stroke or Epilepsy |
| | | <input type="checkbox"/> g. Gastro or Intestinal Disorder | |

Yes No 2. During the past 6 months, have you or any dependent to be covered:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | a. been examined or treated by a physician or other health care provider for any condition, illness, or injury, other than as stated above? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. been advised to have treatment or surgery or testing that has not been done? |
| <input type="checkbox"/> | <input type="checkbox"/> | c. been admitted to a hospital or other health care facility as an inpatient? |
| <input type="checkbox"/> | <input type="checkbox"/> | d. taken prescribed medication? |

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

F. Other/Previous Insurance

Is your spouse employed? Yes No If "Yes", give name and address of your spouse's employer.

If "Yes" to Other Health Coverage (Section D), give name(s) & policy number(s) of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B identify the coverage and provide the Medicare ID #.

If "Yes" to Other Rx Drug Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to Previous Coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number, and submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available.

G. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? Yes No If "Yes", who and at what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

H. Employee Signature *If you have questions concerning the benefits and services provided by or excluded under this policy contact an Employee Benefits Hotline representative at 1-888-600-1600 before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on this Enrollment/Change Request. I authorize deductions from my earnings for any required contributions.

Employee Signature - Required X _____ Date ___/___/___

I. Employer Verification - To be completed by Employer

Employer Signature - Required X _____ Title _____ Date ___/___/___

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Guardian prior to visiting a specialist or admission to a hospital.