Administered by: AlwaysCare

Enrollment Form for Group Insurance

Underwritten by: National Guardian Life Insurance Company
Administered by: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
7800 Office Park Blvd., Baton Rouge, LA 70809-7603,(225)926-2888 or 1-888-729-5433

EMPLOYEE INFORMATION

A: Add (enroll) T: Terminate C: Change (change of name or coverage)

Employer Name	Group Number	Location	Effective Date

☐ A ☐ T ☐ C	Gender ☐ M ☐ F	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City/State/Zip	Home Phone	Work Phone	Cell Phone
			Email:	

COMPLETED BY EMPLOYER

Date of Hire	☐ Full time ☐ Part time If part time: Hrs worked per week: _____	Occupation	Class

Salary $: _____ ☐ Yearly ☐ monthly ☐ bi-monthly ☐ weekly ☐ bi-weekly ☐ hourly

FAMILY INFORMATION (Only those eligible may be enrolled.)

A: Add (enroll) T: Terminate C: Change (change of name or coverage)

☐ A ☐ T ☐ C	Gender ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	
☐ A ☐ T ☐ C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Unmarried child/ FT student/ handicapped? Yes No
☐ A ☐ T ☐ C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
☐ A ☐ T ☐ C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No
☐ A ☐ T ☐ C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Yes No

BENEFIT ELECTIONS (Employer determines benefits available for election):

☐ **Dental** ☐ Waive
- ☐ Employee Only $_____
- ☐ Employee Spouse $_____
- ☐ Employee + Child(ren) $_____
- ☐ Employee Family $_____

☐ **Vision** ☐ Waive
- ☐ Employee Only $_____
- ☐ Employee Spouse $_____
- ☐ Employee + Child(ren) $_____
- ☐ Employee Family $_____

☐ **Basic life / AD&D**
- Employee ☐ Elect ☐ Decline
- Spouse ☐ Elect ☐ Decline
- Children ☐ Elect ☐ Decline

☐ **Supplemental / Voluntary Term Life/AD&D**
- Employee ☐ Elect ☐ Decline $_____or_____ X annual salary
- Spouse ☐ Elect ☐ Decline $_____
- Children ☐ Elect ☐ Decline $_____

☐ **Short Term Disability**
☐ Elect ☐ Decline
If Buy-Up Available: ☐ Elect ☐ Decline

☐ **Long Term Disability**
☐ Elect ☐ Decline
If Buy-Up Available: ☐ Elect ☐ Decline

Beneficiary Information (Complete ONLY for Life or AD&D):

Primary Beneficiary:	Relationship:	Date of Birth:
Contingent Beneficiary:		

In the past 12 months, have you had continuous group coverage (for yourself and/or your dependents) with a prior carrier? ☐ yes ☐ no
If yes, please provide: Policyholder _____ and Insurance Company _____
Important! If declining any coverage for yourself or any dependent, give reason. Covered under: ☐ Spouse's group coverage ☐ Individual insurance ☐ other coverage offered by my employer ☐ other_____

I declare that the information I have completed on this enrollment form is complete and true. I have read and understand the statements on page 2 and understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from National Guardian Life Insurance Company.

Your signature X_____ Date signed _____

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I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. If I refuse dental or vision coverage, I and/or my dependents may enroll later but this will affect the level of benefits. If I refuse life and/or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by National Guardian Life Insurance Company. If I refuse coverage, I cannot enroll after retirement.
- If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution: (1) I authorize my employer to deduct from my pay; and (2) I understand that no insurance is in force until the first premium is paid.
- I represent all information on this form and attachments are complete and true to the best of my knowledge. They are part of this request for coverage. I agree National Guardian Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- I authorize National Guardian Life Insurance Company to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date of signature. I may revoke authorization for information not yet obtained. I understand data obtained will be used by National Guardian Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purpose prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and/or my dependents will be sent to my home address. I also understand collection of social security numbers from myself and/or my dependents will be used by National Guardian Life Insurance Company only as allowed by law.
- NOTE for Dental: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under Coverage A in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date.
- NOTE for Vision: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. These limited coverages also apply to the Late Entrant's or Re-enrollee's Dependents, if enrolled.

A copy of this form will be as valid as the original.

After this form is completed and signed, make two copies and send the original to:

National Guardian Life Company
c/o AlwaysCare Benefits
P.O. Box 98100
Baton Rouge, LA 70898-9100

• Employer – copy of Page 1 and Page 2

• Employee – copy of Page 1 and Page 2