

Guardian Life, P.O. Box 14319,  
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: <b>CAPITAL AREA COMMUNITY ACTION AGENCY</b>	Group Plan Number: <b>00436156</b>	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		

Class: ALL ELIGIBLE EMPLOYEES   Division: \_\_\_\_\_   Subtotal Code: \_\_\_\_\_   (Please obtain this from your Employer)

<b>About You:</b> First, MI, Last Name:	Employer Provided Identification: _____	Social Security Number ____ - ____ - ____ <small>Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.</small>	
Address	City	State	Zip
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy): ____ - ____ - ____		
Phone (indicate primary): <input type="checkbox"/> Home (____) ____ - ____ <input type="checkbox"/> Work (____) ____ - ____ <input type="checkbox"/> Mobile (____) ____ - ____			
Email Address (indicate primary) <input type="checkbox"/> Home _____ <input type="checkbox"/> Work _____			
		Are you married or do you have a partner? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage/union: ____ - ____ - ____
		Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placement date of adopted child: ____ - ____ - ____

<b>About Your Job:</b>	Job Title:	
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra/State Continuation	Date of full time hire: ____ - ____ - ____	Annual Salary: \$ _____
Hours worked per week: _____		

**About Your Family:** Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Your dependent's Social Security Number must be provided if enrolling for Life Coverage. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (wherever the term "Spouse" appears on this form, it also includes "Partner").	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop   Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop   Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 3:	<input type="checkbox"/> Add <input type="checkbox"/> Drop   Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4:	<input type="checkbox"/> Add <input type="checkbox"/> Drop   Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

<p><b>Drop Coverage:</b></p> <p><input type="checkbox"/> Drop Employee    <input type="checkbox"/> Drop Dependents</p> <p>The date of withdrawal cannot be prior to the date this form is completed and signed.</p> <p>Last Day of Coverage: ____ - ____ - ____</p> <p><input type="checkbox"/> Termination of Employment    <input type="checkbox"/> Retirement</p> <p>Last Day Worked: ____ - ____ - ____</p> <p><input type="checkbox"/> Other Event: _____</p> <p>Date of Event: ____ - ____ - ____</p>	<p><b>Coverage Being Dropped:</b></p> <p><input type="checkbox"/> Dental                      <input type="checkbox"/> Employee    <input type="checkbox"/> Spouse    <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Basic Life</p> <p><input type="checkbox"/> Voluntary Life            <input type="checkbox"/> Employee    <input type="checkbox"/> Spouse    <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Short Term Disability</p>
<p><b>Loss Of Other Coverage:</b></p> <p>I and/or my dependents were previously covered under Loss of coverage was due to:</p> <p><input type="checkbox"/> Termination of Employment: ____ - ____ - ____</p> <p><input type="checkbox"/> Divorce/Separation ____ - ____ - ____</p> <p><input type="checkbox"/> Death of Spouse ____ - ____ - ____</p> <p><input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____</p> <p>Coverage Lost    <input type="checkbox"/> Dental</p>	<p>I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:</p> <p><input type="checkbox"/> Covered under another insurance plan</p> <p><input type="checkbox"/> Other _____</p> <p style="text-align: center;">(additional information may be required)</p>

**Dental Coverage:** You must be enrolled to cover your dependents. Check only one box.

Your Bi-weekly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: PPO	<input type="checkbox"/> \$10.82	<input type="checkbox"/> \$21.94	<input type="checkbox"/> \$24.31	<input type="checkbox"/> \$32.97
Option 2: PPO	<input type="checkbox"/> \$16.86	<input type="checkbox"/> \$34.16	<input type="checkbox"/> \$37.86	<input type="checkbox"/> \$51.33

**Basic Life Coverage with Accidental Death and Dismemberment (AD&D):**

*Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

**Policy Amount**

Employee Only

100% of your annual salary to a maximum of \$150,000

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records.

**Primary Beneficiaries:**

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ % \_\_\_\_\_

Date of Birth (mm-dd-yy): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ % \_\_\_\_\_

Date of Birth (mm-dd-yy): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (mm-dd-yy): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Please contact your employer for any record of or changes to your beneficiary information.

Spouse and dependent child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only.  Yes  No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

**Custodian to Minor Beneficiaries:**

Name: \_\_\_\_\_ Social Security Number (or

FEIN/TIN # if a corporate entity): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (mm-dd-yyyy) (if an individual): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy \$ \_\_\_\_\_

**Important Notes:**

- You may be required to complete and evidence of insurability form if you are enrolling after any initial eligibility enrollment period.

**LIFE INSURANCE** *continued*

**Voluntary Term Life Coverage:** You must be enrolled to cover your dependents. *Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

Employee

Policy Amount	<i>Check one box only</i>				
<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$60,000	<input type="checkbox"/> \$70,000
<input type="checkbox"/> \$80,000	<input type="checkbox"/> \$90,000	<input type="checkbox"/> \$100,000*	<input type="checkbox"/> \$110,000	<input type="checkbox"/> \$120,000	<input type="checkbox"/> \$130,000
<input type="checkbox"/> \$140,000	<input type="checkbox"/> \$150,000	<input type="checkbox"/> \$160,000	<input type="checkbox"/> \$170,000	<input type="checkbox"/> \$180,000	<input type="checkbox"/> \$190,000
<input type="checkbox"/> \$200,000**	<input type="checkbox"/> \$210,000	<input type="checkbox"/> \$220,000	<input type="checkbox"/> \$230,000	<input type="checkbox"/> \$240,000	<input type="checkbox"/> \$250,000
<input type="checkbox"/> \$260,000	<input type="checkbox"/> \$270,000	<input type="checkbox"/> \$280,000	<input type="checkbox"/> \$290,000	<input type="checkbox"/> \$300,000	

Guarantee Issue up to: Employee Less than age 65 \$100,000\*, 65-69 \$10,000, \$0. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected. Additional Amount: per employee \$100,000\*\*. The Additional amount is available for ages Less than age 65. An Evidence of Insurability form must be completed if any amount above the Guarantee Issue Amount plus Additional Amount is elected.

I do not want this coverage

**Add Voluntary Life for Spouse**

50% of employee's amount to maximum \$150,000 \$ \_\_\_\_\_

Guarantee Issue up to: Spouse Less than age 65 \$25,000, 65-69 \$5,000, \$0. Additional Amount: Spouse \$25,000\*\*. The Additional amount is available for ages Less than age 65

*\*The amount may not be more than 50% of the employee amount for Voluntary Life.*

I do not want this coverage

**Add Voluntary Life for Dependent/Child(ren)**

10% of employee's amount to maximum \$10,000 \$ \_\_\_\_\_

The Guarantee Issue Amount is \$10,000. The Guarantee Issue with Additional Amount is \$10,000.

*\*The amount may not be more than 10% of the employee amount for Voluntary Life.*

I do not want this coverage

**Important Notes:**

- You may be required to complete and evidence of insurability form if you are enrolling after any initial eligibility enrollment period.

LIFE INSURANCE *continued*

Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life, please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ % \_\_\_\_\_

Date of Birth (mm-dd-yy): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ % \_\_\_\_\_

Date of Birth (mm-dd-yy): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (mm-dd-yy): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Please contact your employer for any record of or changes to your beneficiary information.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only.  Yes  No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: \_\_\_\_\_ Social Security Number (or FEIN/TIN # if a corporate entity): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (mm-dd-yyyy) (if an individual): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Phone: ( ) - \_\_\_\_\_

Short-Term Disability (STD) Coverage:

The amount of STD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you.

*Weekly Benefit*

60% of salary to a maximum of \$1,000

Health History

Complete the following question if you are enrolling for one of more of the following benefits listed below and you are electing an amount above coverage that is Guaranteed Issue. NOTE: Additional information may be required.

Voluntary Life Insurance

In the last 6 months have you or any of your dependents received diagnosis and/or treatment by a licensed medical professional for medical care, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; or any other Chronic Condition? (Being breast cancer free for 2 or more years and any follow-up does not disqualify an applicant.)(A chronic condition is continuous or persistent over an extended period of time. A chronic condition is one that is long-standing, and not easily or quickly resolved.)

Yes, I have.  No, I haven't.  Yes, my spouse has.  No, my spouse hasn't.  Yes, my dependent child(ren) have.  No, my dependent child(ren) haven't.

Have you or any of your dependent tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or AIDS caused by the HIV infection or other sickness or condition derives from such infection ?

Yes, I have.  No I haven't.  Yes, my spouse has.  No, my spouse hasn't.  Yes, my dependent child(ren) have.  No, my dependent child(ren) haven't.

An Evidence of Insurability form must be completed for any person with a "Yes" answer to the questions above.

### Signature

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- LIFE ONLY: I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- 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.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.
- I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.
- 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 acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

SIGNATURE OF EMPLOYEE X \_\_\_\_\_

DATE \_\_\_\_\_

Enrollment Kit 00436156, 0001, EN