GUARDIAN™ The Guardian Life Insurance Company of America

Form No.: GG-011372

Loss of Coverage Statement

☐ Northeast Regional Office
PO Box 26050
Lehigh Valley PA 18002-6050

☐ Midwest Regional Office
PO Box 8012
Appleton WI 54913-8012

☐ Western Regional Office
PO Box 2454
Spokane WA 99210-2454

☐ Norwell Regional Office
PO Box 9121
Norwell MA 02061-9121

Before completing this application, please read the IMPORTANT notice on the reverse side of this form concerning special enrollment rights and preexisting condition limitations.

Section I

When an eligible employee and/or his eligible dependents involuntarily lose coverage under another plan, the employee may complete this form as request for coverage for himself, and/or his dependents. This form or notification must be completed and submitted within 30 days from the date the other coverage ends. Submit an enrollment card only if you are not already enrolled for any Guardian coverage. If coverage under the other plan ended more than 30 days prior to the completion of this form, late entrant penalties may apply to major medical and dental coverages and delays in enrollment may apply to vision coverage.

Section II (All questions must be completed)

Employee Name	Social Security #

1. I hereby certify that I and/or my eligible dependents were insured under the group plan provided by my spouse's employer.

Name of Spouse's Employer	Prior Medical Carrier	Plan No.:	Prior Dental Carrier	Plan No:

Address of Spouse's Employer	Spouse's Employer's Telephone No.: ( )

2. The group plan named above insured the following members of my family for: ☐ Medical ☐ Dental ☐ Vision
☐ Myself & Spouse ☐ Myself & Spouse & Child(ren) ☐ Spouse Only ☐ Spouse & Child(ren) Only

3. Indicate the reason why this coverage is no longer available to you and/or your dependents, and the date coverage ended.

☐ Termination of employment Date _____
☐ Loss of eligibility Date _____
(i.e., reduction of hours, legal separation, divorce, death of spouse)
☐ Termination/expiration of coverage Date _____

4. Provide complete information for each person to be insured:

Full Name (Last, First, MI)	Coverage	Sex	Social Security #	Birthdate	Relationship
	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F			
	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F			
	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F			
	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F			
	☐ Medical ☐ Dental ☐ Vision	☐ M ☐ F			

I represent that all statements and answers given above are true, complete and correct. They shall be part of my application for coverage. I understand that employee coverage will be effective as of the date this form is signed, provided all conditions and requirements in Section I above have been met. Coverage for my dependents will also be effective as of that same date provided I am enrolled for the medical and/or dental and/or vision coverage.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature of Employee **Date**

Section III (To be completed by the Planholder)

The employee whose signature appears above signed this statement in my presence. To the best of my knowledge and belief, the statements and answers given above are true, complete and correct.

Planholder Name		Group Plan #
Planholder Signature	**Title**	**Date**

(5/99)

IMPORTANT NOTICE

The following apply to health plans issued or renewed on or after July 1, 1997.

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Preexisting Condition Limitation:

This group health plan contains a preexisting condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees). The preexisting condition limitation relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months period prior to an individual's enrollment date. This exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the preexisting condition limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any preexisting condition limitation will apply to you, you must present your certificate or certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, or a health plan issued under the Peace Corps Act.

You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO). If necessary, this plan and Guardian will assist you in obtaining a certificate from any of these entities.

This Preexisting Condition Limitation notice is being issued to you pursuant to the Federal Health Insurance Portability and Accountability Act of 1996 and reflects the protection afforded under federal law. If the state law applicable to a fully insured Guardian plan is more beneficial to covered individuals as to the length of the preexisting condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Guardian plan.