Guardian

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

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

Please print clearly and mark carefully.

Employer/Planholder Name: **Bar Association of Erie County**	Group Plan Number: **00104129**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Add Employee/Member Dependents/Family Members ❑ Drop/Refuse Coverage ❑ Information Change

In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term , and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.

Class:_____ Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer/Planholder)**

About You:	**Employer/Planholder Provided Identification:**	**Social Security Number or Taxpayer Identification Number (TIN)**
Full Legal Name-First, MI, Last Name: What is the name you go by? (optional)	_____	___ ___ ___ - ___ ___ - ___ ___ ___ ___ Your Social Security Number or TIN must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.

Address	City	State	Zip

Gender Identity: ❑ M ❑ F Date of Birth (mm-dd-yy): ____ - ____ - ____

Phone (indicate primary): ❑ Home (____) ____ - ____
❑ Work (____) ____ - ____
❑ Mobile (____) ____ - ____

Email Address (indicate primary) ❑ Home _____ ❑ Work _____

Are you married or in a civil union? ❑ Yes ❑ No Date of marriage/civil union:____-____-_____
Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-_____

About Your Job: Job Title:

Work Status: ❑ Active ❑ Retired ❑ COBRA/State Continuation Hours worked per week: _____	Date of full time hire: _____ - _____ - _____	

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 or TIN 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 Address/City/State/Zip: Phone: ( ) -	Gender Identity: ❑ M ❑ F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Oct 08, 2026

Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

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

Your Monthly Premium	Employee/Member Only	Employee/Member, Spouse & Dependent/Child(ren)
PPO	❑ $35.90	❑ $106.24

❑ I do not want Dental Coverage because (Check as applicable):

- ❑ I am covered under another Dental plan
- ❑ My spouse is covered under another Dental plan
- ❑ My dependents/family members are covered under another Dental plan

Vision Coverage: **You must be enrolled to cover your dependents/family members. Check only one box.**

Your Monthly Premium	Employee/Member Only	Employee/Member, Spouse & Dependent/Child(ren)
Full Feature	❑ $5.69	❑ $13.81

❑ I do not want this Vision coverage because (Check as applicable):

- ❑ I am covered under another Vision plan
- ❑ My spouse is covered under another Vision plan
- ❑ My dependents/family members are covered under another Vision plan

Specified Disease Coverage: **You must be enrolled to cover your dependents/family members**

Benefit reductions apply. Please see plan administrator.

Employee/Member Insurance Amount: ❑ $10,000 ❑ $20,000 ❑ $30,000

❑ I do not want this coverage.

Spouse Insurance Amount: Up to 100% of the employee/member's amount to a maximum of $30,000

❑ $10,000 ❑ $20,000 ❑ $30,000

❑ I do not want this coverage.

Dependent/Child(ren)
Insurance Amount: ❑ 50% of the employee/member's amount
❑ I do not want this coverage.

Do you have on the date of this application, other specified disease coverage in force(or pending applications) for the same disease(s) for which you are applying for coverage herein for you and any dependents/family members being enrolled? ❑ Yes. ❑ No.

Please indicate the number of specified diseases for which you have coverage in force(or pending applications)for yourself and any dependents/family members being enrolled. Under NY law, you may be covered for a maximum of 7 specified diseases. A policy may not be issued that results in you becoming covered for 8 or more specified diseases.
Employee/Member_____ dependents/family members:_____

Important Note: A pre-existing conditions limitation may apply for a period of time after your coverage effective date, as stated in your plan. Read your plan carefully.

Employee/Member Only - Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term 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/Member:**_____

Name:_____ **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee/Member:**_____

Contingent Beneficiary:_____ **Social Security Number:** ___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee/Member:**_____

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

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, 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: ( ) -

Accident Coverage

You must be enrolled to cover your family members.

Your Monthly premium	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Dependent/Child(ren)	Employee/Member, Spouse & Dependent/Child(ren)
	❑ $7.07	❑ $11.57	❑ $11.84	❑ $16.34

❑ I do not want this coverage.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term 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/Member:**_____

Name:_____ **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___ %_____

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee/Member:**_____

Contingent Beneficiary:_____ **Social Security Number:** ___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee/Member:**_____

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

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, 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: ( ) -

Hospital Indemnity Coverage

You must be enrolled to cover your dependents/family members. Check only one box.

Your Monthly premium	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Child(ren)	Employee/Member, Spouse & Child(ren)
	❑ $37.75	❑ $75.53	❑ $50.21	❑ $87.97
	❑ I do not want this coverage.	❑ I do not want this coverage.	❑ I do not want this coverage.	❑ I do not want this coverage.

Important Notes:

- A pre-existing conditions limitation may apply for a period of time after your coverage effective date, as stated in your plan. Read your plan carefully.

Signature

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- HOSPITAL INDEMNITY ONLY: This is a limited plan of Hospital Indemnity insurance. It is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a 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.

- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I agree that my employer/planholder or my employer/planholder's designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.
- **I state that the information provided above is true and correct to the best of my knowledge and belief.**

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

I understand that this is accident-only,hospital indemnity,and/or specified disease insurance. It does not provide coverage for sickness. This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with my taxes. By my signature below, I affirmatively acknowledge that I have comprehensive hospital, surgical and medical health insurance. Please contact us at 1-800-541-7846 if you have questions about the benefits provided by this coverage.

The laws of New York require the following statement appear: Any person who 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE/MEMBER X _____ **DATE _____**

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: 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.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

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Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she 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.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.