

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

Please print clearly and mark carefully.

Employer/Planholder Name: NEW ERA INFORMATION TECH., LLC	Group Plan Number: 00516591	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Employee/Member Dependents/Family Members <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> 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: _____ Sublocal Code: _____ (Please obtain this from your Employer/Planholder)

About You: Full Legal Name-First, MI, Last Name: What is the name you go by? (optional)	Employer/Planholder Provided Identification:	Social Security Number
Address	City	State
Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy):	Zip
Phone (indicate primary): <input type="checkbox"/> Home () - - - - <input type="checkbox"/> Work () - - - - <input type="checkbox"/> Mobile () - - - -	Your Social Security Number must be provided if enrolling for Life Coverage, Short Term Disability Coverage and/or Long Term Disability Coverage.	
E mail Address (indicate primary) <input type="checkbox"/> Home _____ <input type="checkbox"/> Work _____	Date of marriage/civil union: - - - -	
Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> 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: - - - - Annual Salary: \$ _____

About Your Family: Please include the names of the Dependents/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.

If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.

Spouse	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Address/City/State/Zip:	Date of Birth (mm-dd-yyyy)	
Phone: () -		

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Child/Dependent 1: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number Date of Birth (mm-dd-yyyy)	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number Date of Birth (mm-dd-yyyy)	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number Date of Birth (mm-dd-yyyy)	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number Date of Birth (mm-dd-yyyy)	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

Drop Coverage:

Drop Employee/Member Drop Dependents/Family Members

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____

Termination of Employment Retirement
 Last Day Worked: _____

Other Event: _____
 Date of Event: _____

Coverage Being Dropped:

Dental Employee/Member Spouse Child(ren)
 Vision Employee/Member Spouse Child(ren)
 Basic Term Life Voluntary/ Term Life

Loss Of Other Coverage:

I and/or my dependents were previously covered under Loss of coverage was due to:

Termination of Employment: _____
 Divorce/Separation: _____
 Death of Spouse: _____
 Termination/Expiration of Coverage: _____
 Coverage Lost Dental Vision

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:
 Covered under another insurance plan
 Other _____
 (additional information may be required)

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

Employee/Member Only Employee/Member & Spouse Employee/Member, Spouse & Dependent/Child(ren) Employee/Member, Spouse & Dependent/Child(ren)

PPD 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.

Full Feature
 Employee/Member Only
 Employee/Member & Spouse
 Employee/Member, Spouse & Dependent/Child(ren)

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

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.

Policy Amount
 Employee/Member Only
 \$50,000
 The Guarantee Issue Amount is \$50,000.
 * If Employee/Member is 65+ benefit reductions may apply which may change the GI amount. Please see enrollment materials for details.

I do not want this coverage.

Employee/Member 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/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.)

Dependents/Family Members – (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-yy) (if an individual): _____
 Address/City/State/Zip: _____
 Phone: () - _____

If this Basic Life coverage will replace your existing life insurance coverage through your current Employer/Planholder, provide the amount of the previous policy \$ _____

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

Signature

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
 - 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.
 - 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 attest that the information provided above is true and correct to the best of my knowledge.
- Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

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

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.
- 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.

