GUARDIAN®

PCI™ Pennsylvania Chamber Insurance

ENROLLMENT FORM FOR NON-MEDICAL COVERAGES

EMPLOYER NAME:		BUSINESS PHONE:		ORG ID (Account number):
1. EMPLOYEE NAME (Last, First, Middle Initial):		2. SEX: ☐ MALE ☐ FEMALE		3. SOCIAL SECURITY NUMBER:
4. EMPLOYEE ADDRESS (Number and Street):	5. CITY:	6. STATE:	7. ZIP CODE:	8. PHONE NUMBER:
9. DATE OF BIRTH	10. DATE OF HIRE:	11. SALARY ☐ Weekly ☐ Hourly ☐ Annually $_____		12. HOURS WORKED WEEKLY:
13. JOB TITLE:	14. WORK STATUS: Are you actively at work? ☐ Yes ☐ No	15. WORK DUTIES: Are you able to perform the duties of your occupation? ☐ Yes ☐ No		16. EFFECTIVE DATE:

COVERAGE SELECTION(S): Your employer will inform you of available coverages: ☐ **LATE APPLICANT**

LIFE INSURANCE OPTIONS			
☐	Life / AD&D	☐ Add ☐ Delete	
☐	Dependent Life	☐ Add ☐ Delete	
☐	Supplemental Life	☐ Add ☐ Change ☐ Delete	AMOUNT: $_____
VOLUNTARY DISABILITY INSURANCE OPTIONS			
☐	Short Term Disability Plan: _____	☐ Add ☐ Change ☐ Delete ☐ I decline coverage	BENEFIT AMOUNT: $_____ PREMIUM AMOUNT: $_____
☐	Long Term Disability Plan: _____	☐ Add ☐ Change ☐ Delete ☐ I decline coverage	BENEFIT AMOUNT: $_____ PREMIUM AMOUNT: $_____
GROUP SHORT TERM DISABILITY			
☐	Plan: _____	☐ Add ☐ Change ☐ Delete	BENEFIT AMOUNT: $_____ PREMIUM AMOUNT: $_____

In the past two years, have you missed 5 or more consecutive work days for a sickness, injury or chronic condition other than a cold or flu? ☐ YES ☐ NO
In the past two years, have you missed more than 10 days, in total, due to a single sickness, injury or chronic condition? ☐ YES ☐ NO

If you responded "yes" to either of the above, please provide details.

BENEFICIARY DESIGNATION: Must be completed. If you have additional beneficiaries, please attach a separate sheet. ☐ **Change in Beneficiary**

NAME:	DATE OF BIRTH:	SOCIAL SECURITY #:	RELATIONSHIP:	BENEFIT %:
PRIMARY: ☐ Life ☐ Disability				
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CONTINGENT BENEFICIARY: *(used only if the above beneficiary dies before you do)*				

I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that any request to change this decision may not be approved unless I provide satisfactory evidence of insurability.

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

DECLINATION OF COVERAGE: If I have waived the insurance, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and Guardian reserves the right to reject my request.

- I hereby apply for the group benefit(s) indicated above.
- I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service.
- I understand that insurance coverage for my dependents will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex.
- I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance.
- The information provided above is true and correct to the best of my knowledge.
- 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 be guilty of insurance fraud.

Employee Signature _____ Date _____/_____/_____ GRD-EF 10/13