Employee Enrollment / Change Form

Insured by:
Guardian Life Insurance Company of America

NOTE: PLEASE COMPLETE ALL INFORMATION

Inshore, C/O: Pathian, 32110 Agoura Road, Westlake Village, CA 91361
(800) 786-6525 • Fax (818) 960-0141 • inshore@pathianadministrators.com

☐ **NEW ENROLLMENT** ☐ **OPEN ENROLLMENT** ☐ **CHANGE** ☐ **REINSTATE** (Must be done within 30 days of original term date)

EFFECTIVE DATE OF ADD / CHANGE (MM/DD/CCYY)

TYPE OF CHANGE:

☐ **Add Dependent(s)*** Date:
☐ **Cancel Employee** Last Date of Coverage:
☐ **Cancel Dependent(s)*** Last Date of Coverage:
***List Names Below**

☐ **Address Change**
☐ **Transfer to COBRA**
☐ Federal COBRA ☐ State COBRA

☐ **Other** _____

NAME (Last)	(First)	(M.I)	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH** (MM/DD/CCYY)
ADDRESS	Apt. #	City	State	Zip Code
TELEPHONE **HOME: ( )**		**WORK: ( )**	**E-MAIL ADDRESS**	
EMPLOYER NAME	**EMPLOYER ADDRESS**		**DATE OF HIRE** (MM/DD/CCYY)	

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* **Last Name First Name M.I.**	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH** (MM/DD/CCYY)	**GENDER**	***If you choose a Guardian Dental HMO Option: Enter your choice of Dental Office Number below***	**EXISTING PATIENT** Yes	No	***(Check one)***
Employee			☐ M ☐ F	PCD ID#	☐	☐	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	PCD ID#	☐	☐	☐ Add ☐ Cancel
Dependent* Relationship			☐ M ☐ F	PCD ID#	☐	☐	☐ Add ☐ Cancel
Dependent* Relationship			☐ M ☐ F	PCD ID#	☐	☐	☐ Add ☐ Cancel
Dependent* Relationship			☐ M ☐ F	PCD ID#	☐	☐	☐ Add ☐ Cancel

Dental Plan Options

DHMO
☐ Low-Option DHMO
☐ High-Option DHMO

DPPO
☐ 1500 Standard DPPO
☐ 1500 UCR DPPO
☐ 2000 Standard DPPO
☐ 2500 UCR DPPO

Life Insurance Options

Basic Life
☐ $5,000
☐ $15,000
☐ $25,000
☐ $50,000

Voluntary Term Life
☐ $_____
Based on $10,000 increments

I hereby apply for the group benefit(s) that I have chosen above.
I understand that I must meet eligibility requirements for all coverage that I have chosen above.
I understand that my dependent(s) cannot be enrolled for coverage if I am not enrolled for that coverage.
I agree that my employer may deduct premiums from my pay or add premiums to my dues; 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 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. By my signature below, I acknowledge that Inshore, An Administrator, endorses the Guardian plan of insurance.

EMPLOYEE'S SIGNATURE	**DATE**	**EMPLOYER'S SIGNATURE**	**DATE**

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