



Thank you for choosing the UUA Group Life & LTD Insurance Plan provided by Guardian.

Submit this cover page along with the completed Guardian enrollment form\* to the UUA group insurance fax: 617-948-6487 or mail to: UUA GIP, 24 Farnsworth St Boston, MA 02210-1409. To email your form, first email [insuranceplans@uua.org](mailto:insuranceplans@uua.org) to request a link to our secure email service.

Congregation/Employer Full Name: \_\_\_\_\_

Congregation Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Congregation 4 Digit ID Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Employee's Email Address: \_\_\_\_\_

Date of Hire (MM/DD/YYYY): \_\_\_\_\_ Annual Salary (plus housing if applicable) \$ \_\_\_\_\_

I have attached the employee's completed enrollment form. Yes \_\_\_\_\_ No \_\_\_\_\_

**\*Instructions for completing the Guardian enrollment form:**

- Please do not complete the "Benefit Effective" date field in the second box.
- Employee must read and complete the enrollment form, beginning with the "Employee" section and finishing by signing and dating the second page of the enrollment form.
- **It is important to make sure to complete the fields for Date Work Status Began and Annual Salary/Earnings. Enrollment cannot be processed without this information.**

An email confirmation is sent to the employee once the form is processed. The email includes the effective date of coverage and the plan Certificate.

Questions? Contact the Insurance Plans Coordinator, at [insuranceplans@uua.org](mailto:insuranceplans@uua.org)

Again, thank you for choosing a UUA benefit plan!

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

Please print clearly and mark carefully.

Employer Name: <b>UNITARIAN UNIVERSALIST ASSOCIATION</b>	Group Plan Number: <b>00494594</b>	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Re-Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		
<input type="checkbox"/> Increase Amount <input type="checkbox"/> Family Status Change		

Class: <b>ALL ELIGIBLE CONGREGATIONAL STAFF AND COMMUNITY</b>	Subtotal Code: _____	(Please obtain this from your Employer)
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<b>About You:</b> First, MI, Last Name:	<b>Social Security Number</b> _____ - _____ - _____	
Address	City	State Zip
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy): ____ - ____ - ____	Phone: ( ) - -
Email Address:	Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage/union: ____ - ____ - ____
	Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placement date of adopted child: ____ - ____ - ____

<b>About Your Job:</b>	Job Title:
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra/State Continuation Hours worked per week: _____	Date of full time hire: ____ - ____ - ____  Annual Salary: \$ _____

**About Your Family:** Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

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

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 all that apply) <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 all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

<b>Drop Coverage:</b> <input type="checkbox"/> Drop Employee <input type="checkbox"/> Drop Dependents The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: ____ - ____ - ____ <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement Last Day Worked: ____ - ____ - ____ <input type="checkbox"/> Other Event: _____ Date of Event: ____ - ____ - ____	<b>Coverage Being Dropped:</b> <input type="checkbox"/> Basic Life <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Long Term Disability
I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____ (additional information may be required)	

**Basic Life Coverage with Accidental Death and Dismemberment (AD&D):** You must be enrolled to cover your dependents.  
*Benefit reductions apply. Please see plan administrator.*

Policy Amount Employee Only 200% of your annual salary to a maximum of \$200,000 The Guarantee Issue Amount is \$200,000.  I do not want this coverage	Spouse \$10,000 <i>*The amount may not be more than 50% of the employee amount</i>  I do not want this coverage.	Child/Dependent \$5,000 <i>*The amount may not be more than 10% of the employee amount</i>  I do not want this coverage	Name your beneficiaries: (Primary beneficiary percentages must total 100%)  Primary Beneficiaries: Name: _____ Social Security Number: ____ - ____ - ____ % Date of Birth (mm-dd-yy): ____ - ____ - ____ Address/City/State/Zip: _____ Phone: ( ) - _____ Relationship to Employee: _____  Name: _____ Social Security Number: ____ - ____ - ____ % Date of Birth (mm-dd-yy): ____ - ____ - ____ Address/City/State/Zip: _____ Phone: ( ) - _____ Relationship to Employee: _____  Contingent Beneficiary: _____ Social Security Number: ____ - ____ - ____ Date of Birth (mm-dd-yy): ____ - ____ - ____ Address/City/State/Zip: _____ Phone: ( ) - _____ Relationship to Employee: _____  (In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)  Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.
If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy \$ _____			
<b>Important Notes:</b> <ul style="list-style-type: none"> <li>Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Basic Life.</li> </ul>			

<b>Long-Term Disability (LTD) Coverage:</b>  Monthly Benefit 60% of salary to a maximum of \$6,000                    I do not want this coverage.
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Signature

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- 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.
- I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.
- I understand that my coverage will not be effective until approved by 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.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.
- "Caution: If you answers on this application are incorrect or untrue, Guardian has the right to deny benefits or rescind your policy."

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 hereto, 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.

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 X \_\_\_\_\_

DATE \_\_\_\_\_

Enrollment Kit 00494594, 0001, EN

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.

Connecticut, Iowa, Kansas, Nebraska, Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

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.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

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.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in [N.H. Rev. Stat. Ann. § 638:20](#)

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.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

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.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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.