



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 [insurance\\_plans@uua.org](mailto:insurance_plans@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 Tamika Mayes, Insurance Plans Coordinator, at [insurance\\_plans@uua.org](mailto:insurance_plans@uua.org)

Again, thank you for choosing a UUA benefit plan!



The Guardian Life Insurance Company of America

**Basic Life and LTD Enrollment / Change Form**

Congregation Name			Guardian Group Plan No.: 00494594	Congregation ID number:
Congregation Street Address	City	State	Zip	

**EMPLOYER USE ONLY:**  New Enrollment  Add Dependent(s)  Drop Dependent(s)  Change Address  Change Name  Drop Coverage as of: / /

Class 0002 - All Eligible Congregational Staff & Community Ministers with 750 hours worked per year.	Hours Worked	Division 0001	Benefit Effective
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Keep a copy for your records and return to: UUA Insurance Plans: 24 Farnsworth Street, Boston, MA 02210 or Fax to: 617-948-6487

**EMPLOYEE** Please provide this information about YOURSELF.

First, Middle Initial, Last Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy)	Social Security Number	
Address		City	State	Zip
Preferred Email Address to send Coverage Confirmation to:	Business Phone#	Home Phone #		
Job Title:	Work Status/Eligibility: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Date work status began:	Annual Salary/Earnings: \$	

ARE YOU MARRIED/PARTNERED?  Yes  No

DO YOU HAVE CHILDREN OR OTHER DEPENDENTS?  Yes  No

**DISABILITY**

**CHOOSE YOUR LONG TERM DISABILITY (LTD) INSURANCE.**

**LTD PLAN**

**MONTHLY BENEFIT:**

66.67% OF SALARY TO MAXIMUM \$6,000 PER MONTH

I WAIVE THIS COVERAGE

**LIFE INSURANCE**

**CHOOSE YOUR BASIC LIFE WITH EMPLOYEE ACCIDENTAL DEATH COVERAGE:**

Employee: <input type="checkbox"/> 200% of salary to maximum \$200,000 <input type="checkbox"/> I waive this coverage	Spouse/DP: <input type="checkbox"/> \$10,000 <input type="checkbox"/> I Waive This Coverage.	Child(ren) <input type="checkbox"/> \$5,000 <input type="checkbox"/> I Waive This Coverage.
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\*If electing for dependents, please add their information below\*

**NAME YOUR BENEFICIARIES – MUST ADD UP TO 100%**

PRIMARY BENEFICIARY 1	PRIMARY BENEFICIARY 2	CONTINGENT BENEFICIARY
Name (Last, First, MI)	Name (Last, First, MI)	Name (Last, First, MI)
Relationship to you: %	Relationship to you: %	Relationship to you: %

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

**IMPORTANT NOTES**

- If you waive life coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian reserves the right to reject your request.
- Children will not be covered until they reach 14 days.

**DEPENDENTS** Please provide this information if you wish to enroll your dependents in life insurance coverage.

<input type="checkbox"/> Add <input type="checkbox"/> Change	Spouse First, Middle Initial, Last Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy)	Social Security Number
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<input type="checkbox"/> Add <input type="checkbox"/> Change	Child (1):	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Full-time student, at (school):	City/State	Attending Since
<input type="checkbox"/> Add <input type="checkbox"/> Change	Child (2):	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Full-time student, at (school):	City/State	Attending Since
<input type="checkbox"/> Add <input type="checkbox"/> Change	Child (3):	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Full-time student, at (school):	City/State	Attending Since
<input type="checkbox"/> Add <input type="checkbox"/> Change	Child (4):	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Full-time student, at (school):	City/State	Attending Since

To drop coverage for yourself or your dependents, check the box(es) to the left of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverage's.  Basic Life  Long Term Disability  Dependent Life

**SIGNATURE**

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverage's that I have chosen above.
- I understand that I must be actively at work or my life and/or disability coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
- I understand that my dependent(s) cannot be enrolled for 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 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 understand that this form must be submitted within 60 days of my hire date in order to be accepted.
- 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.

SIGNATURE OF EMPLOYEE

DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO  
**UUA Insurance Plans**  
**24 Farnsworth Street, Boston, MA 02210 or Fax to: 617-948-6487**