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 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 Rachael Brennan, Insurance Plans Coordinator, at insurance_plans@uua.org

Again, thank you for choosing a UUA benefit plan!

GUARDIAN®

The Guardian Life Insurance Company of America

Basic Life and LTD Enrollment / Change Form

Congregation Name	Guardian Group Plan No.:	Congregation ID number:
	00494594	

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	Hours Worked	Division	Benefit Effective
0002 - All Eligible Congregational Staff & Community Ministers with 750 hours worked per year.		**0001**	

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: ☐ M ☐ 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: ☐ Full Time ☐ 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:

☐ 200% of salary to maximum $200,000

☐ I waive this coverage

Spouse/DP:

☐ $10,000

☐ I Waive This Coverage.

If electing for dependents, please add their information below

Child(ren)

☐ $5,000

☐ I Waive This Coverage.

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.

☐ Add ☐ Change	Spouse First, Middle Initial, Last Name	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	Social Security Number

☐ Add ☐ Change	Child (1):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since
☐ Add ☐ Change	Child (2):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since
☐ Add ☐ Change	Child (3):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since
☐ Add ☐ Change	Child (4):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐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