UUA Group Dental Insurance Plan provided by Guardian Dental

Retiree Dental Enrollment

Group Option: When you retire, *if you qualify as outlined below*, you may apply to continue your dental coverage with our group, **as a retiree**, rather than as an employee. The coverage and cost are the same as when you were an employee; you pay the monthly cost. Notify the UUA Office of Church Staff Finances (OCSF) insurance_plans@uua.org of your date of retirement and tell us whether you wish to continue any of your eligible benefits, including your dental benefit.

Other: If you do *not* qualify to continue with our group plan as a retiree, and you were enrolled with our dental coverage on the day immediately preceding the date of retirement, you may instead elect enrollment under COBRA. COBRA coverage generally ends 18 months after you retire, and there is a 2% fee on the monthly premium. Regulations ensure that there is no gap between your group dental coverage and your COBRA dental coverage when you enroll within the mandated timeframe. Notify us if you do not receive your COBRA dental enrollment election materials within 30 days of retirement.

To qualify to apply for coverage with our group as a retiree, a person must:

- have been enrolled in our group dental plan on the day immediately preceding the date of retirement.
- be at least 62 years of age at retirement, and
- have a retirement date of 01-01-2013 or beyond, and
- have worked a minimum of 750 hours for the employer and/or as a recognized community minister for at least 5 of the past 10 years.
- If you qualify to continue with our group as a retiree, complete the dental enrollment application* within 30 days of retirement, and your coverage will be continuous. Keep a copy for your files.

***Instructions for Retirees completing the Guardian dental enrollment form:**

- Please do *not* complete the benefits effective date or Division and Subtotal codes
- Read and complete the form, beginning with "About You"
- Disregard references to the "Employee". Check the "Retiree" box.
- Be sure to sign and date the second page of the form.
- Submit the completed Guardian Dental enrollment form to the UUA group insurance office by **fax: 617-948-6487** or by mail: UUA GIP, 24 Farnsworth St, Boston, MA 02210
- Our office serves as group administrator for the plan

An email confirmation is sent to you once the form is processed. The email will include the effective date of your retiree dental coverage and information on how to use the dental plan.

Questions? Contact Tamika Mayes, Insurance Plans Coordinator, at insurance_plans@uua.org

Thank you for choosing a UUA benefit plan!

This form is for residents of every state EXCEPT Texas

Thank you for choosing the UUA Group Dental Insurance Plan provided by Guardian for your dental coverage.

Submit this cover page along with the completed Guardian Dental 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): _____

I have attached the employee's completed enrollment form. Yes_____ No____

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

- **Please do not complete the Benefits Effective Date, coverage will be effective on 1/1/19 if you are enrolling during open enrollment. At other times coverage is effective on the day after we receive your completed form.**
- **Please enter Division 1 and enter your four digit Congregation ID in the Subtotal Code field.**
- **Employee's email address must be entered above in order to receive confirmation of enrollment and the plan certificate**
- **Employee must read and complete the dental enrollment form, beginning with "About You", and finishing by signing and dating the second page of the enrollment form.**

An email confirmation is sent to the employee once the form is processed. The email includes the effective date of coverage and information on how to use the dental plan. Questions? Contact Tamika Mayes, Insurance Plans Coordinator, at insurance_plans@uua.org

Again, thank you for choosing a UUA benefit plan!

GUARDIAN®

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

Please print clearly and mark carefully.

Employer Name: **UNITARIAN UNIVERSALIST ASSOCIATION**	Group Plan Number: **00533436**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Re-Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change ❑ Increase Amount ❑ Family Status Change

Class: Class Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:

First, MI, Last Name:	Social Security Number ___-___-____	
Address	City	State / Zip
Gender: ❑ M ❑ F	Date of Birth (mm-dd-yy):___-___-___	Phone: ( ) -
Email Address:	Are you married or do you have a spouse? ❑ Yes ❑ No Do you have children or other dependents? ❑ Yes ❑ No	Date of marriage/union:___-___-___ Placement date of adopted child:___-___-___

About Your Job: Hours worked per week: _____ Job Title:

Work Status: ❑ Active ❑ Retired ❑ Cobra/State Continuation	Date of full time hire: ___-___-___	

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 (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender ❑ M ❑ F	Social Security Number ___-___-___ Date of Birth (mm-dd-yyyy) ___-___-___	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ___-___-___ Date of Birth (mm-dd-yyyy) ___-___-___	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ___-___-___ Date of Birth (mm-dd-yyyy) ___-___-___	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Dec 05, 2016

Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____-____-____ Date of Birth (mm-dd-yyyy) ____-____-____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____-____-____ Date of Birth (mm-dd-yyyy) ____-____-____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

Drop Coverage:

❑ Drop Employee ❑ Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Dental ❑ Employee ❑ Spouse ❑ Child(ren)

Loss Of Other Coverage:

I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to:

❑ Termination of Employment: _____-_____-_____

❑ Divorce _____-_____-_____

❑ Death of Spouse _____-_____-_____

❑ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ❑ Dental

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

Dental Coverage: **You must be enrolled to cover your dependents. Check only one box.**

	Employee Only	Employee and 1 Dependent	EE, Spouse & Dependent/Child(ren)
PPO	❑	❑	❑

❑ I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:

- ❑ I am covered under another Dental plan
- ❑ My spouse is covered under another Dental plan
- ❑ My dependents are covered under another Dental plan

Signature

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- 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.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by a 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.

Guardian Group Plan Number: **00533436**

Please print employee name:

- **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 00533436, 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.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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, Nebraska, and 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.

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.

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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 or 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 or denial of insurance benefits.

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.

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.

GUARDIAN® **The Guardian Life Insurance Company of America**

And its Affiliates and Subsidiaries

Midwest Regional Office
PO Box 8012
Appleton WI 54912-8012

Northeast Regional Office
PO Box 26040
Lehigh Valley, PA 18002-6040

Western Regional Office
PO Box 2454
Spokane, WA 99210-2454

NOTICE OF INFORMATION PRACTICES FORM

Thank you for choosing The Guardian Life Insurance Company of America ("Guardian"). This notice is given to you at the time you apply for life or disability insurance to tell you about the kinds of information we may obtain in connection with your application. Your personal information may be collected from a person other than you. We will treat all personal information about you as confidential, except as authorized by you, or as required by law. Such personal information as well as other personal or privileged information subsequently collected by Guardian or our representatives may in certain circumstances be disclosed to a third party without authorization.

You have a right of access and correction with respect to your personal information. If you wish a more detailed explanation of our information practices, please send your written request to: The Privacy Office, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-4025.

MIB, Inc. Pre-Notice: Information regarding your insurability will be treated as confidential. Guardian, or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. member company for life, health or disability insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc., at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the information in your MIB, Inc. file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc., information office is 50 Braintree Hill Park, Suite 400, Braintree MA 02184-8734.

Guardian, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, health, or disability insurance, or to whom a claim for benefits may be submitted.

Medical Records: We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.