GUARDIAN | phs health plans™ You Matter.™

Northwest Regional Office
P.O. Box 26050
Lehigh Valley, PA 18002-6050

ENROLLMENT/CHANGE FORM - NEW YORK

- **Please print clearly and in Black Ink**
- **Please print in Capital Letters only**

Planholder Name | Group Plan Number | Division | Class

1. TRANSACTION TYPE:	TYPE OF CHANGE: *(To add or cancel deps. list names in Sec 4.)*	FOR GUARDIAN USE:
☐ New Applicant ☐ Open Enroll ☐ Change in Enroll ☐ Refusal of Coverage	☐ Cancel Employee* ☐ Add Dependents ☐ Cancel Dependents* ☐ PCP Change ☐ Term of Emp. ☐ Birth ☐ Marriage ☐ Transfer to COBRA ☐ Other Ins. ☐ Marriage ☐ Divorce ☐ Retirement ☐ Adoption ☐ Chg. Student Status ☐ Beneficiary Change ☐ Other ☐ Other	EFF. DATE: EE Cov./$: Dep. Cov./$:

2. CHANGE DATE:

3. EMPLOYEE INFORMATION

Employee Name (Last) | (First) | (MI) | Sex ☐ M ☐ F

Social Security Number | Birth Date (MM DD YYYY) | Primary Care Physician | PCP Access #

Street Address

City | State | ZIP

Home Phone ( ) - | Occupation/Job Title

Are you: ☐ Actively at work ☐ Retired? | New Address? ☐ Yes ☐ No | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Hours worked per week: | Annual Salary (nearest dollar) , , | Date of F/T Hire (MM DD YYYY)

4. DEPENDENTS INFORMATION

Spouse Name (First) | (MI) | (Last - if differs from employee's last name) | Sex ☐ M ☐ F

Social Security Number | Birth Date (MM DD YYYY) | Primary Care Physician | PCP Access #

Child Name (First) | (MI) | (Last - if differs from employee's last name) | Student ☐ Y ☐ N | Sex ☐ M ☐ F

Social Security Number | Birth Date (MM DD YYYY) | Primary Care Physician | PCP Access #

Child Name (First) | (MI) | (Last - if differs from employee's last name) | Student ☐ Y ☐ N | Sex ☐ M ☐ F

Social Security Number | Birth Date (MM DD YYYY) | Primary Care Physician | PCP Access #

Child Name (First) | (MI) | (Last - if differs from employee's last name) | Student ☐ Y ☐ N | Sex ☐ M ☐ F

Social Security Number | Birth Date (MM DD YYYY) | Primary Care Physician | PCP Access #

Signature: _____ Date: (MM DD YYYY)

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Group Plan Number

Employee's Social Security Number

5. ADDITIONAL DEPENDENT INFORMATION

a) Do you have any dependent children? ☐Yes ☐No

b) If Dependent Child(ren) listed are over the limiting age and attend school on a full time basis, list name and address of school. _____

c) Have you included stepchildren? ☐Yes ☐No If "Yes", indicate name. _____

d) Are they dependent on you for support & maintenance? ☐Yes ☐No

e) Are any dependents currently disabled? ☐Yes ☐No If "Yes", indicate name(s). _____

(Pursuant to Federal Law, this information will not be used to determine eligibility for medical coverage.)

f) Do any dependents reside at a different address than indicated above? ☐Yes ☐No If "Yes," list name and address. _____

6. COVERAGE SELECTION

Employee: ☐ Life ☐ AD&D ☐ Opt. Life $_____

☐ Major Medical (select only one)
- ☐ Indemnity
- ☐ PPO Network
- ☐ HMO
- ☐ POS

☐ Dental
- ☐ Indemnity
- ☐ PPO
- ☐ Prepaid

☐ Vision

☐ Short Term Disability ☐ Electing Buy-up STD
Optional STD Weekly Maximum $_____ up to 50% of salary

☐ Long Term Disability ☐ Electing Buy-up LTD
Optional LTD Weekly Maximum $_____ up to 50% of salary

Dependents cannot be enrolled for coverages declined by the employee

Spouse:
- ☐ Life ☐ Opt. Life $_____
- ☐ Medical ☐ Rx Card
- ☐ Vision ☐ Dental

Child(ren):
- ☐ Life ☐ Opt. Life $_____
- ☐ Medical ☐ Dental
- ☐ Vision

7. REFUSAL OF INSURANCE ***(read the Refusal of insurance Statement on Reverse)***

I decline the following coverages:

Myself:	☐ Life	☐ Optional Life	☐ Vision	☐ Medical (HMO/POS/PPO/Indemnity)	☐ Dental	☐ STD	☐ LTD
Spouse:	☐ Life	☐ Optional Life	☐ Vision	☐ Medical (HMO/POS/PPO/Indemnity)	☐ Dental		
Child(ren):	☐ Life	☐ Optional Life	☐ Vision	☐ Medical (HMO/POS/PPO/Indemnity)	☐ Dental		

BENEFICIARY DESIGNATION: ***(Include full proper name and relationship; i.e. MARY A. JONES, WIFE)***

NAME: ***RELATIONSHIP:***

8. Is your spouse employed? ☐Yes ☐No If "Yes", name and address of employer:

Do you or your dependents have other health insurance under a group plan, HMO or Medicare? ☐Yes ☐No If "Yes", complete this section

Name of Person	Employer	Policy #

Insurance Company Name & Address	Medicare
	Part ☐A ☐B

Applicable to Accident and Health Coverages: "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 act, which is a crime, *and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.*"

The information provided on this form is true and correct to the best of my knowledge, and I accept the provisions on this form which I have read and understand.

Signature: _____ Date: ____ ____ | ____ ____ | ____ ____ ____ ____

(MM DD YYYY)

DISCLAIMER:

In Connecticut, coverage under the HMO and Point-of-Service plan is provided by Physicians Health Services of Connecticut, Inc., One Far Mill Crossing, Shelton, CT 06484. ***In New York***, coverage under the HMO and in-network portion of the Point-of-Service plan is provided by Physicians Health Services of New York, Inc., 399 Knollwood Road, White Plains, NY 10603. ***In New Jersey***, coverage under the HMO and Point-of-Service plan is provided by Physicians Health Services of New Jersey, Inc., Mack Center IV, South 61, Paramus Road, Paramus, NJ 07652.
Indemnity coverage, PPO coverage, the out-of-network portion of the Point-of-Service plan in New York, and ancillary lines of coverage are underwritten by Guardian Indemnity Contract Number GP-1-R3-1.0 et al. New York Out-of-Network POS Contract Number GP-1-JV-HCS-NY-1

REFUSAL OF INSURANCE:

If the plan requires contributions, and I have refused the coverage, the terms for requesting coverage at a later date are as follows: I will not be eligible for the HMO or POS plans until the next open enrollment period; unless coverage is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or unless a court has ordered coverage be provided for a spouse or minor child. To apply for any other coverage, if available, I will be required to furnish, at my own expense, proof of insurability and the Guardian reserves the right to reject my request. Proof of insurability does not apply to major medical or dental coverages; however, late entrant penalties may apply.
THE FOLLOWING SPECIAL ENROLLMENT RIGHTS APPLY TO PLANS ISSUED OR RENEWED ON OR AFTER JULY 1, 1997: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

AGREEMENT:
I understand the benefits and coverage as summarized in the contract and that these benefits are administered strictly as specified in the contract. I hereby (1) request coverage for the Group program for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for coverage, or agree that the contribution be added to my dues, if applicable; (3) state that I became an employee on the date stated on this form, and do currently work the number of hours per week stated on this form. I understand that, in order to be accepted for HMO/POS/PPO coverage, my signed and completed application for coverage must be received by The Guardian & PHS Healthcare Solutions within 31 days of my initial eligibility for coverage or within 31 days of the next open enrollment effective date.

I authorize any physician, hospital, insurer or other organization or person having any records or information concerning the health and treatment (including psychiatric and substance abuse) of me and my family member(s) to furnish such records as may be requested by The Guardian & PHS Healthcare Solutions or its authorized representative. A photocopy or digital image of this authorization shall be considered as valid as the original.

I certify that all dependents listed on this form are eligible for coverage under the terms of the contract. I agree to notify The Guardian & PHS Healthcare Solutions and my employer within 31 days when such eligibility ceases. I understand that The Guardian & PHS Healthcare Solutions are not liable to provide coverage for ineligible dependents.

IMPORTANT NOTICE

The following applies to indemnity major medical plans.

Preexisting Condition Limitation: This group health plan contains a preexisting condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees). The preexisting condition limitation relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months period prior to an individual's enrollment date. This exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the preexisting condition limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. ***(For Connecticut plans***, if your prior creditable coverage was lost due to an involuntary termination of employment, the plan will not take into account any days of creditable coverage that precede a break of more than 90 days prior to your effective date, provided you apply within 63 days of your initial eligibility.) To determine if any preexisting condition limitation will apply to you, you must present your certificate or certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy, Part A or B of Medicare, Medicaid, CHAMPUS, a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, or a health plan issued under the Peace Corps Act.

You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO). If necessary, your employer and Guardian will assist you in obtaining a certificate from any of these entities.

The Preexisting Condition Limitation notice is being issued to you pursuant to the Federal Health Portability and Accountability Act of 1996 and reflects the protection afforded under federal law. If the state law applicable to a fully insured Guardian plan is more beneficial to covered individuals as to the length of the preexisting condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Guardian plan.