Personnel Department

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AUTHORIZATION FOR PAYROLL DEDUCTION FOR VOLUNTARY DENTAL EFFECTIVE YEAR 2022

Effective Date: _____

I hereby authorize payroll deductions for the following Dental Insurance Plan with Essex County:

NOTE: Deductions are taken the first two (2) pay periods of each month. Premiums are due the month prior for the next month (i.e. deduction in January for February coverage).

GUARDIAN

The payroll deduction for this plan will be as follows:

☐ Individual Plan $62.02 per month
☐ Family Plan $158.58 per month

☐ Pre-Tax Deduction
☐ After-Tax Deduction

_____
Print Name **Date**

_____
Employee Signature

Guardian

Group Insurance Enrollment/Change Form

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

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

Please print clearly and mark carefully.

Employer Name: **ESSEX COUNTY**	Group Plan Number: **00357744**	Benefits Effective:_____
PLEASE CHECK APPROPRIATE BOX Initial Enrollment	Add Employee/Dependents	Drop/Refuse Coverage Information Change

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

About You: First, MI, Last Name:	**Employer Provided Identification:** _____	**Social Security Number or Taxpayer Identification Number (TIN)** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Your Social Security Number of TIN must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	

Address	City	State	Zip

Gender: M F Date of Birth (mm-dd-yy): ____ - ____ - ____

Phone (indicate primary): Home (____) ____ - ____
Work (____) ____ - ____
Mobile (____) ____ - ____

Email Address (indicate primary) Home _____ Work _____

Are you married or do you have a partner? Yes No Date of marriage/union: ____ - ____ - ____
Do you have children or other dependents? Yes No Placement date of adopted child: ____ - ____ - ____

About Your Job: Job Title:

Work Status: Active Retired Cobra/State Continuation Hours worked per week: _____	Date of full time hire: ____ - ____ - ____	

About Your Family: Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Your dependent's Social Security Number or TIN must be provided if enrolling for Life Coverage. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional infomration mau be required for non-standard dependents such as a grandhcild, a niece or a nephew.

Spouse (wherever the term "Spouse" appears on this form, it also includes "Partner"). Address/City/State/Zip: Phone: ( ) -		Gender M F	Social Security Number or TIN ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number or TIN ____ - ____ - ____ 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

Child/Dependent 2:	Add Drop	Gender M F	Social Security Number or TIN	Status (check all that apply)
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy)	Student (post high school) Disabled Non standard dependent
Phone: ( ) -				
Child/Dependent 3:	Add Drop	Gender M F	Social Security Number or TIN	Status (check all that apply)
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy)	Student (post high school) Disabled Non standard dependent
Phone: ( ) -				
Child/Dependent 4:	Add Drop	Gender M F	Social Security Number or TIN	Status (check all that apply)
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy)	Student (post high school) Disabled Non standard dependent
Phone: ( ) -				

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 Loss of coverage was due to:

Termination of Employment: _____-_____-_____

Divorce/Separation _____-_____-_____

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	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.

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.

Guardian Group Plan Number: **00357744** Please print employee name:

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 agree that my [employer] or my employer's designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.

By my signature below, I affirmatively consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice

By my signature below, I affirmatively 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 state that the information provided above is true and correct to the best of my knowledge.

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 thereto, 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 00357744, 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.

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.

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.

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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.

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.