Guardian Coverage Changes

To drop dependents:

- Guardian Insurance Change Form (Page 2)

To add dependents:

- Guardian Insurance Change Form (Page 2)
- Guardian Insurance Enrollment Form (Page 3)

To drop Guardian insurance:

- Guardian Insurance Change Form (Page 2)

To switch Guardian insurance:

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- Guardian Insurance Enrollment Form (Page 3)

To enroll in a Guardian insurance plan:

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Please send completed forms to Kris Akut, Benefits Coordinator.

2022 Guardian Insurance Change Form

Last Name:_____ **First Name:**_____

Moody ID #: _____

My CURRENT Guardian Coverage is:

Place an "x" on the field that applies

None _____

Accident		Hospital Indemnity		Critical Illness	
Employee	_____	Employee	_____	Employee	_____
Empl. + Spouse	_____	Empl. + Spouse	_____	Empl. + Spouse	_____
Empl. + Child(ren)	_____	Empl. + Child(ren)	_____	Employee coverage amount:	$_____
Family	_____	Family	_____	Spouse coverage amount:	$_____

I am CURRENTLY covering the following dependent(s):

Name of Dependent:_____

Name of Dependent:_____

Name of Dependent:_____

I would like my NEW Guardian coverage to be:

Place an "x" on the field that applies

Drop all coverage_____

Accident		Hospital Indemnity		Critical Illness	
Employee	_____	Employee	_____	Employee	_____
Empl. + Spouse	_____	Empl. + Spouse	_____	Empl. + Spouse	_____
Empl. + Child(ren)	_____	Empl. + Child(ren)	_____	*Employee coverage amount:	$_____
Family	_____	Family	_____	*Spouse coverage amount:	$_____

I would like to ADD or DROP the following dependent(s):

☐ **Add**** Name of Dependent:_____ Birth date:_____/_____/_____
☐ **Drop** Relationship to you: _____

☐ **Add**** Name of Dependent:_____ Birth date:_____/_____/_____
☐ **Drop** Relationship to you: _____

☐ **Add**** Name of Dependent:_____ Birth date:_____/_____/_____
☐ **Drop** Relationship to you: _____

Effective Date of Change: 01/01/2022

Signature of Employee:_____ **Date:**_____/_____/_____

*If you are changing the amount or adding your spouse to the critical Illness coverage you must fill out the **Enrollment Form.**

** If you are adding new children to your coverage, you must fill out an **Enrollment Form.**

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

Please print clearly and mark carefully.

Employer Name: The Moody Bible Institute of Chicago	Group Plan Number: 00578473	Benefits Effective:_____

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

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: 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. 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 dependent tax exemption. Dependent 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: Nov 04, 2020

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

Critical Illness Coverage:

You must be enrolled to cover your dependents

Benefit reductions apply. Please see plan administrator.

Employee
Insurance Amount: ❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000 ❑ $25,000 ❑ $30,000

❑ I do not want this coverage.

Spouse
Insurance Amount: Up to 50% of the employee's amount to a maximum of $15,000

❑ $2,500 ❑ $5,000 ❑ $7,500 ❑ $10,000 ❑ $12,500 ❑ $15,000

❑ I do not want this coverage.

Dependent/Child(ren)
Insurance Amount: ❑ 25% of the employee's amount

❑ I do not want this coverage.

Have you used any form of tobacco in the past 6 months (e.g. pipe, chewing tobacco) and/or have you smoked cigarettes in the past 12 months?

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

IMPORTANT NOTES:

- Based on your plan benefits and age, you may be required to complete an additional evidence of insurability form for Critical Illness.

Accident Coverage

You must be enrolled to cover your dependents.

Your Semi-monthly premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
	❑ $6.33	❑ $10.19	❑ $10.69	❑ $14.55

❑ I do not want this coverage.

Hospital Indemnity Coverage

You must be enrolled to cover your dependents. Check only one box.

Your Semi-monthly premium	Employee Only	EE & Spouse	EE & Child(ren)	EE, Spouse & Child(ren)
	❑ $11.18	❑ $23.50	❑ $17.10	❑ $29.42

Applicants over the age of 69 are not eligible to enroll in the Hospital Indemnity coverage.

❑ I do not want this coverage.	❑ I do not want this coverage.	❑ I do not want this coverage.	❑ I do not want this coverage.

Signature

- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- 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.
- 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.
- I attest 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 _____

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.

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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.

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.