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

**Please print clearly and mark carefully.**

| Employer/Planholder Name: UMASS CHAN MEDICAL SCHOOL | Group Plan Number: 00549499 | Benefits Effective:_____ |
|---|---|---|

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Add Employee/Member Dependents/Family Members ❑ Drop/Refuse Coverage ❑ Information Change

In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term , and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.

Class: SHORT TERM DISABILITY Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer/Planholder)**

## About You:

Full Legal Name-First, MI, Last Name:

What is the name you go by? (optional)

**Employer/Planholder Provided Identification:**

_____

**Social Security Number**

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

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

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

Email Address (indicate primary) ❑ Home _____ ❑ Work _____

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

## About Your Job:

Job Title:

| Work Status:<br>❑ Active ❑ Retired ❑ COBRA/State Continuation<br>Hours worked per week: _____ | Date of full time hire: _____ - _____ - _____ | Annual Salary: $_____ |
|---|---|---|



DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

*DATE FORM PUBLISHED: Mar 21, 2025*

## Drop Coverage:

❑ Drop Employee/Member ❑ Drop Dependents/Family Members

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:

❑ Basic Term Life

❑ Voluntary Term Life

❑ Short Term Disability

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)

## Short-Term Disability (STD) Coverage:

The amount of STD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

*Weekly Benefit*

❑ 60% of salary to a maximum of $3,500

❑ I do not want this coverage.

## Signature

- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- 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.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. 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.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- **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, may be guilty of committing a fraudulent insurance act as determined by a court of law, which may be 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.**

SIGNATURE OF EMPLOYEE/MEMBER X _____ DATE _____