GUARDIAN

HealthPass SM NEW YORK

Guardian Life Insurance Company of America

EverGuard Late Enrollment Form

Employer Name:		HealthPass Group ID #	
Employer Address:	City:	State:	Zip:

GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED

Employee Name: (Last, First, Middle Initial)	Sex: M☐ F☐	Birthdate:	Employee's Social Security #
Date of Full-time Employment:	Hrs Worked/Week:	Annual Salary:	Occupation/Job Title:
Employee's Street Address:		City:	State: Zip:
Business Phone:	Home Phone:		

Beneficiary Name (Last, First, Middle) Relationship and %

1. _____

2. _____

In the last 6 months, have you received medical treatment, consultation, care or services, including diagnostic measures or took prescribed drugs for: Cardiovascular Disease; Cancer; any condition related to Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex; or any other life threatening condition? Employee Yes☐ No☐

AN EVIDENCE OF INSURABILITY FORM(S) MUST BE COMPLETED FOR ANY EMPLOYEE WITH A "YES" ANSWER TO THE ABOVE QUESTION

☐ I elect coverage for Basic Life, AD&D, & LTD

- I hereby apply for the group benefit indicated above
- I understand I must be actively at work or my Life/Disability Coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service.
- I authorize my employer to take deductions from my pay.
- This 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 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:	DATE:

Please retain a photocopy for your records and submit this form to HealthPass.