



Employer:  
**Redwood Children's Services, Inc.**  
**780 South Dora St**  
**Ukiah, CA 95482**

Guardian Group Plan Number: **419595**  
 Plan Administrator: **Angie Hernandez**

The Guardian Life Insurance Company of America

|   |              |          |                           |
|---|--------------|----------|---------------------------|
| <b>EMPLOYER USE ONLY</b> <input type="checkbox"/> New Application <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Drop Dependent(s) <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name <input type="checkbox"/> Drop Coverage as of: / / |              |          |                           |
| Class<br><b>1 - All Eligible Employees</b>  | Hours Worked | Division | Benefits Effective<br>/ / |
| Keep a copy for your records and return form to: <b>Western Regional Office, P.O. Box 2454, Spokane, WA 99210-2454</b>  |              |          |                           |

|  |   |  |   |
|--|---|--|---|
| <b>ABOUT YOURSELF</b> <span style="float: right;"><i>Print clearly in black or blue ink.</i></span>  |   |  |   |
| First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop  | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F  | Date of Birth (mm/dd/yyyy)<br>/ /  | Social Security Number<br>- -   |
| Address  | City  | State  | Zip   |
| Preferred E-mail   | Day Phone   | Eve Phone  | The best way to reach you:<br><input type="checkbox"/> E-mail <input type="checkbox"/> Day Phone <input type="checkbox"/> Eve Phone |
| Job Title  | Work Status<br><input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation | Date work status began<br>/ /  | Annual Salary/Earnings<br>\$  |
| Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No If you have a domestic partner (DP), is your partnership registered with the State of California? <input type="checkbox"/> Yes <input type="checkbox"/> No |   | Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |

|   |  |                                   |  |                      |                        |
|---|--|-----------------------------------|--|----------------------|------------------------|
| <b>ABOUT YOUR DEPENDENTS</b> <input type="checkbox"/> A sheet with information about additional dependents is attached.   |  |                                   |  |                      |                        |
| Spouse/DP First, Middle Initial, Last Name<br><input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop  | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth (mm/dd/yyyy)<br>/ / | Social Security Number<br>- -                            | Marriage Date<br>/ / |                        |
| Child 1 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop  | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth (mm/dd/yyyy)<br>/ / | <input type="checkbox"/> Full-time student, at (school): | City/State:          | Attending Since<br>/ / |
| Child 2 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop  | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth (mm/dd/yyyy)<br>/ / | <input type="checkbox"/> Full-time student, at (school): | City/State:          | Attending Since<br>/ / |
| Child 3 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop  | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth (mm/dd/yyyy)<br>/ / | <input type="checkbox"/> Full-time student, at (school): | City/State:          | Attending Since<br>/ / |
| Child 4 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop  | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth (mm/dd/yyyy)<br>/ / | <input type="checkbox"/> Full-time student, at (school): | City/State:          | Attending Since<br>/ / |
| To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages.<br><input type="checkbox"/> Basic Life <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical |  |                                   |  |                      |                        |

|  |  |
|--|--|
| <b>YOUR BASIC LIFE COVERAGE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&amp;D)</b>   |  |
| <b>Policy Amount</b>   |  |
| Employee   | <input checked="" type="checkbox"/> \$25,000 |
| If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy \$ _____ |  |

**LIFE INSURANCE** *continued*

| Name your beneficiaries                                |                          | Primary beneficiaries must total 100%. |   |
|--|--------------------------|--|---|
| Primary Beneficiary 1 First, Middle Initial, Last Name | Relationship to Employee | Percent                                |   |
| Primary Beneficiary 2                                  |                          |  | % |
| Contingent Beneficiary                                 |                          |  | % |

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

**IMPORTANT NOTES**

- If you waive life or disability coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian reserves the right to reject your request.

| CHOOSE YOUR DENTAL COVERAGE |  |  | <i>Check one box only</i> |  |
|-----------------------------|--|--|---------------------------|--|
| Employee alone              | <b>PPO</b><br><input type="checkbox"/> |  |                           | <input type="checkbox"/> I waive this coverage |
| Employee and Spouse/DP      | <input type="checkbox"/>               |  |                           | <input type="checkbox"/> I waive this coverage |
| Employee and Child(ren)     | <input type="checkbox"/>               |  |                           | <input type="checkbox"/> I waive this coverage |
| Entire family               | <input type="checkbox"/>               |  |                           | <input type="checkbox"/> I waive this coverage |

**If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.**

|  |  |
|--|--|
| Reason for Loss of coverage: <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Spouse/DP<br><input type="checkbox"/> Termination or Expiration of coverage | Date of coverage loss<br>/ /   |
| If you are waiving coverage, are you covered under another dental plan?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | If you are waiving dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |

**IMPORTANT NOTES**

- Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse/DP, divorce or where a court has ordered coverage be provided for an eligible spouse/DP or eligible children, provided you apply within 30 days.

| CHOOSE YOUR MEDICAL AND PRESCRIPTION DRUG COVERAGE   |                          |   | <i>Check one box only</i>                      |
|--|--------------------------|---|--|
|  | <b>PPO</b>               |   |  |
| Employee alone   | <input type="checkbox"/> |   | <input type="checkbox"/> I waive this coverage |
| Employee and Spouse/DP   | <input type="checkbox"/> |   | <input type="checkbox"/> I waive this coverage |
| Employee and Child(ren)  | <input type="checkbox"/> |   | <input type="checkbox"/> I waive this coverage |
| Entire family  | <input type="checkbox"/> |   | <input type="checkbox"/> I waive this coverage |
| If you are waiving coverage, are you covered under another medical plan?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                          | If you are waiving dependent coverage, are your dependents covered under another medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Does another carrier or Medicare cover you or your dependents for medical insurance? <input type="checkbox"/> Yes. <input type="checkbox"/> No. If Yes, please provide the following:  |                          |   |  |
| Name of Employee's other carrier   | Plan Number              | Effective Date (MM/DD/YR)   | Carrier's phone number                         |
| Spouse/DP's  |                          | (MM/DD/YR)  |  |
| Child(ren)'s   |                          | (MM/DD/YR)  |  |
| <input type="checkbox"/> Additional carriers for other dependents are included on a separate sheet.  |                          |   |  |
| If you or your family have lost medical coverage, please explain below. <i>Special enrollment rights apply.</i>  |                          |   |  |
| Reason for Loss of coverage:<br><input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Spouse/DP <input type="checkbox"/> Termination or Expiration of coverage |                          |   |  |
| Date of coverage loss: (MM/DD/YR)  |                          |   |  |

## IMPORTANT NOTES

**Unless state law provides otherwise, the following apply to health plans issued or renewed on or after July 1997:**

- **Special Enrollment Rights:** If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) 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 apply for enrollment within 30 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 apply for enrollment within 30 days of the marriage, birth adoption or placement for adoption. You may also enroll as a late enrollee at any time other than for those situations explained above.
- **Pre-existing Condition Limitation:** This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.
- This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.
- All questions about the pre-existing condition exclusion and creditable coverage should be directed to our Member Services Department at PO Box 8008 Appleton WI 54912 or 1-800-873-4542.
- The Pre-existing Condition Limitation notice is being issued to you pursuant to the Federal Health Insurance 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 pre-existing condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your Guardian plan.

| CHOOSE YOUR VISION COVERAGE   |  |  | Check one box only |  |
|---|--|--|--------------------|--|
| Employee alone  | Full Feature<br><input type="checkbox"/> |  |                    | <input type="checkbox"/> I waive this coverage |
| Employee and Spouse/DP  | <input type="checkbox"/>                 |  |                    | <input type="checkbox"/> I waive this coverage |
| Employee and Child(ren)   | <input type="checkbox"/>                 |  |                    | <input type="checkbox"/> I waive this coverage |
| Entire family   | <input type="checkbox"/>                 |  |                    | <input type="checkbox"/> I waive this coverage |
| If you are waiving coverage, are you covered under another vision plan?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | If you are waiving dependent coverage, are your dependents covered under another vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |                    |  |

### IMPORTANT NOTES

- If I have waived the vision coverage, and elect coverage at a later date, enrollment delays may apply.
- Your plan includes a One Year Lock-In/Lock-Out Provision - Your election to enroll in or waive vision coverage must remain in effect until your plan's next annual vision enrollment period.

### SIGNATURE

- 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 understand that I must be actively at work or my life and/or disability coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- I understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
- **I attest that the information provided above is true and correct to the best of my knowledge.**
- **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 be guilty of insurance fraud.**

SIGNATURE OF EMPLOYEE **X**

DATE