

Planholder Name (Company Name) <b>DATTCO, Inc.</b>		Group Plan No. <b>335601</b>		Payroll	Class
Planholder Street Address <b>583 South Street</b>		City <b>New Britain</b>		State <b>CT</b>	Zip <b>06051</b>
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> INITIAL APPLICATION					
CHANGE: <input type="checkbox"/> INCREASE <input type="checkbox"/> ADD DEPENDENT(S) <input type="checkbox"/> TERMINATE A FAMILY MEMBER <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME <input type="checkbox"/> DELETE COVERAGE					
DATE OF CHANGE ___/___/___ REASON FOR CHANGE _____					
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced			DEPENDENT CHILDREN <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED</b>					
Name (Last, First, Middle Initial)		Social Security #	Sex	Birthdate	
Employee:			<input type="checkbox"/> M <input type="checkbox"/> F		
Spouse:			<input type="checkbox"/> M <input type="checkbox"/> F	Date of Marriage ____/____/____	
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(1) Are any dependent children adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name and date of placement:					
(2) Have you included stepchildren? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name(s):					
				Are they dependent on you for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Full Time Employment	Hrs. Worked / Week	Annual Salary \$	Occupation /Job Title	Beneficiary Name (Last, First, Middle), Relationship and %	
Employee's Street Address			City	1. _____ %	
State	Zip	Business Phone #	Home Phone #	2. _____ %	
Have you or your spouse used any form of tobacco in the past 6 months (e.g., pipe, chewing tobacco) or smoked cigarettes in the past 12 months?					
Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", specify: Type: Amount Used:					
<b>BASIC LIFE WITH ACCIDENTAL DEATH &amp; DISMEMBERMENT</b>					
Employee: <input checked="" type="checkbox"/> You have coverage provided for you by your company in the amount of 1 X's your annual salary to a maximum of \$50,000, if you meet eligibility requirements.					
<b>VOLUNTARY TERM LIFE</b>					
Employee:		Spouse: (50% of emp amt to \$100,000)		Child(ren): (10% of emp amt to \$10,000)	
<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$100,000		<input type="checkbox"/> Yes <input type="checkbox"/> No*		<input type="checkbox"/> Yes <input type="checkbox"/> No*	
<input type="checkbox"/> \$50,000 <input type="checkbox"/> \$150,000				(Less than 14 days is not covered)	
<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> I decline coverage.*				(14 days to 6 months is limited to a \$500 benefit)	
SHORT TERM DISABILITY: Employee: <input checked="" type="checkbox"/> Core Plan Coverage has been paid for you by your company if you meet eligibility requirements.					
Buy Up Option: <input type="checkbox"/> I elect coverage. <input type="checkbox"/> I decline coverage.*					
<b>LONG TERM DISABILITY</b>					
<input type="checkbox"/> I elect coverage. <input type="checkbox"/> I decline coverage.*					
<b>DENTAL</b>					
Employee:		Spouse:		Child(ren):	
<input type="checkbox"/> I elect coverage.		<input type="checkbox"/> Yes <input type="checkbox"/> No***		<input type="checkbox"/> Yes <input type="checkbox"/> No***	
<input type="checkbox"/> I decline coverage. I understand if I elect coverage at a later date, late entrant penalties will apply. **					
** If declining coverage, are you covered under another dental plan? Yes No					
*** If declining dependent coverage, are your dependents covered under another dental plan? Yes No					
<b>DECLINATION OF COVERAGE:</b>					
If I have waived the insurance, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish, at my own expense, proof of each person's insurability, and Guardian reserves the right to reject my request.					
<ul style="list-style-type: none"> <li>I hereby apply for the group benefit(s) indicated above.</li> <li>I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service.</li> <li>I understand that insurance coverage for my dependents will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex.</li> <li>I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance.</li> <li>The information provided above is true and correct to the best of my knowledge and belief.</li> <li>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.</li> </ul>					
<b>XSIGNATURE OF EMPLOYEE</b>				<b>DATE</b>	

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN