

The Guardian Life Insurance Company of America

Midwest Regional Office
P.O. Box 8012
Appleton, WI 54913-8012

Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040

Norwell Regional Office
P.O. Box 9121
Norwell, MA 02061-9121

Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

GG-013499 Enrollment Form For Non-Medical Coverages

Planholder Name (Company Name)		Group Plan No.		Division	Class
Planholder Street Address			City	State	Zip
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	
GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED					
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
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	Occupation /Job Title			
Employee's Street Address			City		
State	Zip	Business Phone #	Home Phone #		
DENTAL					
Employee: <input type="checkbox"/> I elect PPO Plan. <input type="checkbox"/> I elect MDG Plan. – Please include Dental Office # if selecting MDG Plan only. Employee's Dental Office # _____ <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? <input type="checkbox"/> Yes <input type="checkbox"/> No *** If declining dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No*** Spouse's Dental Office # _____		Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No*** Child's Dental Office # _____	
DECLINATION OF COVERAGE:					
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"> • I hereby apply for the group benefit(s) indicated above. • I understand I must be actively at work or my life coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. • I understand that life 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. • 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. • 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. 					
X SIGNATURE OF EMPLOYEE				DATE	

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