



The Guardian Life Insurance Company of America
The Guardian Insurance & Annuity Company, Inc.



Highland Capital Markets, 1100 Broadway, Suite 1100, New York, NY 10018

GG-013499NY
Enrollment Form
For Non-Medical Coverages

- Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012
- Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040
- Bridgewater Office
P.O. Box 425
E. Bridgewater, MA
02333-0425
- Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Planholder Name (Company Name)		Group Plan No.	Division	Class
Planholder Street Address		City	State	Zip

MARITAL STATUS: Single Married Widowed Legally Separated Divorced

PLEASE CHECK REASON FOR COMPLETING: INITIAL APPLICATION

CHANGE: ADD DEPENDENT(S) TERMINATE A FAMILY MEMBER ADDRESS NAME DELETE COVERAGE

DATE OF CHANGE ___/___/___ **REASON FOR CHANGE** _____

GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED

Name (Last, First, Middle Initial)	Sex	Birthdate	Employee's Social Security #
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? Yes No If "yes", indicate name and date of placement:
 (2) Have you included stepchildren? Yes No If "yes", indicate name(s):
 (3) Are they dependent on you for support and maintenance? Yes 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: I elect coverage. 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

Spouse: Yes No***

Child(ren): Yes No***

*** If declining dependent coverage, are your dependents covered under another dental plan? Yes No

DECLINATION OF COVERAGE:

Proof of insurability does not apply to dental, but I will be considered a late entrant and my dental benefits will be limited for specific periods of time. However, I and/or my dependents will not be subject to late entrant penalties if dental coverage under another plan is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or where a court has ordered coverage be provided for an eligible spouse or eligible minor child(ren), and application for this plan and documentation of the loss of other coverage is received within 31 days of the termination of such coverage.

- I hereby apply for the group benefit(s) indicated above.
- 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.
- 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