



The Guardian Life Insurance Company of America



Enrollment / Change Form

- 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 02333-04251
- 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

PLEASE CHECK REASON FOR COMPLETING: NEW ENROLLMENT ADD DEPENDENT(S) DROP DEPENDENT(S) CHANGE ADDRESS
 CHANGE NAME DROP COVERAGE AS OF:

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		

WORK STATUS/ELIGIBILITY: FULL TIME PART TIME RETIRED COBRA OR STATE CONTINUATION SINCE: _____
 MARITAL STATUS: SINGLE MARRIED DATE OF MARRIAGE: _____ WIDOWED SEPERATED DIVORCED
 DO YOU HAVE CHILDREN OR OTHER DEPENDENTS? Yes No

Date of Full Time Employment	Hrs. Worked / Week	Annual Salary	Occupation / Job Title
		\$	
Employee's Street Address		City	State Zip
The best way to reach you: <input type="checkbox"/> Day Phone <input type="checkbox"/> Evening Phone <input type="checkbox"/> Email		Business Phone#	Home Phone # Email Address

BENEFICIARY(S) - MUST ADD UP TO 100%	SECONDARY BENEFICIARY	CONTINGENT BENEFICIARY
PRIMARY BENEFICIARY Name (Last, First, MI)	Name (Last, First, MI)	Name (Last, First, MI)
Relationship %	Relationship %	Relationship %

<input type="checkbox"/> Drop	Spouse:	Social Security #	<input type="checkbox"/> M <input type="checkbox"/> F	Birthdate
<input type="checkbox"/> Drop	Child:	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Drop	Child:	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Drop	Child:	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Drop	Child:	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	

To drop coverage for yourself or your dependents, check the box(es) to the left 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. Basic Life Basic Protection Plan Long Term Disability Short Term Disability Dental

BASIC LIFE
 Employee: I elect coverage I decline coverage
 \$25,000 for 100% Participation relative to the whole group OR \$15,000 for 50% participation relative to dental

SIGNATURE

- I hereby apply for the group coverage(s) that I have chosen above.
- I understand that I must meet the 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 coverage if I am not enrolled for that coverage.
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverages I have chosen above.
- I attest that the information provided above is true and correct to the best of my knowledge.
- **Any person knowingly and 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 civil penalty not to exceed five thousand dollars and stated value of the claim for reach such violation (does not apply to life insurance).**

SIGNATURE OF EMPLOYEE	DATE
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PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN