



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

- Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012
 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-013500
Enrollment Form
For Non-Medical Coverages

Planholder Name (Company Name)	Group Plan No.	Division	Class
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Planholder Street Address	City	State	Zip
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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	Annual Salary \$	Occupation /Job Title
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Employee's Street Address	City
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State	Zip	Business Phone #	Home Phone #
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Beneficiary Name (Last, First, Middle),Relationship and %	Beneficiary Name (Last, First, Middle),Relationship and %
_____ %	_____ %

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

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.

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