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: ☐ **INITIAL APPLICATION**

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

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

MARITAL STATUS
☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

DEPENDENT CHILDREN
☐ Yes ☐ No

GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED

Name (Last, First, Middle Initial)	Social Security #	Sex	Birthdate	
Employee:		☐ M ☐ F		
Spouse:		☐ M ☐ F		Date of Marriage / /
Child:		☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
Child:		☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
Child:		☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
Child:		☐ M ☐ F		Full Time Student? ☐ Yes ☐ 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):
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 PPO Plan.**
☐ **I elect MDG Plan. – Please include Dental Office # if selecting MDG Plan only.**
Employee's Dental Office #_____

Spouse: ☐ Yes ☐ No***
Spouse's Dental Office #_____

Child(ren): ☐ Yes ☐ No***
Child's Dental Office #_____

☐ **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 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