Enrollment / Change Form

GUARDIAN®

The Guardian Life Insurance Company of America

Planholder Name (Company Name)			Guardian Group Plan No.:
Planholder Street Address	City	State	Zip

EMPLOYER USE ONLY: ☐ New Enrollment ☐ Add Dependent(s) ☐ Drop Dependent(s) ☐ Change Address ☐ Change Name ☐ Drop Coverage as of: / /

Class	Hours Worked	Division	Benefit Effective

Keep a copy for your records and return to: Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012

EMPLOYEE — Please provide this information about YOURSELF.

First, Middle Initial, Last Name	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	Social Security Number

Address	City	State	Zip

The best way to reach you: ☐ Day Phone ☐ Evening Phone ☐ Email	Business Phone#	Home Phone #	Preferred Email

Job Title:	Work Status/Eligibility: ☐ Full Time ☐ Part Time ☐ Retired ☐ Cobra/State Continuation	Date work status began:	Annual Salary/Earnings: $

ARE YOU MARRIED? ☐ Yes ☐ No

DO YOU HAVE CHILDREN OR OTHER DEPENDENTS? ☐ Yes ☐ No

IF YOU HAVE A DOMESTIC PARTNER, IS YOUR PARTNERSHIP REGISTERED WITH THE STATE OF CALIFORNIA? ☐ Yes ☐ No

DEPENDENTS — Please provide this information about your DEPENDENTS.

A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

☐ Add ☐ Change ☐ Drop	Spouse First, Middle Initial, Last Name	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	Social Security Number	Marriage Date	
☐ Add ☐ Change ☐ Drop	Child (1):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since
☐ Add ☐ Change ☐ Drop	Child (2):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since
☐ Add ☐ Change ☐ Drop	Child (3):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since
☐ Add ☐ Change ☐ Drop	Child (4):	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	☐Full-time student, at (school):	City/State	Attending Since

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 coverage's. ☐ Basic Life ☐ Long Term Disability ☐ Short Term Disability

LIFE INSURANCE

CHOOSE YOUR BASIC LIFE WITH EMPLOYEE ACCIDENTAL DEATH COVERAGE:

Employee:
☐ $_____
☐ I Waive This Coverage

Spouse/DP:
☐ $_____
The amount my not be more than 50% / 100% of the employee amount.
☐ I Waive This Coverage.

Child(ren)
☐ $_____
The amount may not be more than 10% of the employee amount.
☐ I Waive This Coverage.

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy $_____

NAME YOUR BENEFICIARIES – MUST ADD UP TO 100%

PRIMARY BENEFICIARY 1	PRIMARY BENEFICIARY 2	CONTINGENT BENEFICIARY
Name (Last, First, MI)	Name (Last, First, MI)	Name (Last, First, MI)
Relationship to you: %	Relationship to you: %	Relationship to you: %

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

IMPORTANT NOTES

- If you waive life coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian reserves the right to reject your request.
- Children will not be covered until they reach 14 days.
- Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Voluntary Life

DISABILITY

CHOOSE YOUR SHORT TERM DISABILITY (STD) INSURANCE.

STD Plan
Weekly Benefit:
☐ $_____

☐ I Waive This Coverage.

Elect STD BUY-UP
Weekly Benefit:
☐ $_____

The sum of the amounts of you buy-up benefit and your core plan benefit may not exceed 70% of your weekly salary.

CHOOSE YOUR LONG TERM DISABILITY (LTD) INSURANCE.

LTD Plan
Weekly Benefit:
☐ $_____

☐ I Waive This Coverage

Elect LTD BUY-UP
Weekly Benefit:
☐ $_____

The sum of the amounts of you buy-up benefit and your core plan benefit may not exceed 70% of your weekly salary.

SIGNATURE

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverage's 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 coverage I have chosen above.
- I attest that 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.

SIGNATURE OF EMPLOYEE	DATE

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