Guardian Life Insurance Company of America
Group Insurance Enrollment Form

Check reason for completing form:

Western Regional Office
PO Box 2454
Spokane, WA 99210-2454

Northeast Regional Office
P.O. Box 26050
Lehigh Valley, PA 18002-6050

☐ New Subscriber ☐ Delete Coverage ☐ Add a Family Member
☐ Change Address ☐ Change Name ☐ Terminate a Family Member
Date of Change _____ Reason for Change_____

PLANHOLDER NAME (COMPANY NAME).		GROUP PLAN NO.	DIVISION
PLANHOLDER STREET ADDRESS	CITY	STATE	ZIP

EMPLOYEE INFORMATION ***(PLEASE PRINT LEGIBLY AS THIS INFORMATION WILL BE DIRECTLY INPUT INTO OUR SYSTEM)***

FIRST NAME	MIDDLE	LAST NAME	SOC. SEC. NO.	BIRTHDATE	SEX

EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP	SALARY

OCCUPATION/JOB TITLE	CLASS	DATE OF FULL-TIME EMPLOYMENT	HOURS WORKED PER WEEK

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

DEPENDENT CHILDREN?
☐ Yes ☐ No

COVERAGE ELECTION

DENTAL

EMPLOYEE: ☐ **I elect coverage.** **SPOUSE:** ☐ Yes ☐ No** **CHILD(REN):** ☐ Yes ☐ No**

☐ **I decline coverage** (this also waives **ALL** dependent Dental 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

VISION

EMPLOYEE: ☐ **I elect coverage.** **SPOUSE:** ☐ Yes ☐ No** **CHILD(REN):** ☐ Yes ☐ No**

☐ **I decline coverage** (this also waives **ALL** dependent Dental 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

One Year Lock-In/Lock-Out

- Your election to enroll in or waive Vision Plan coverage must remain in effect for 12 months (i.e., Jan 1, 2009 through Dec 31, 2010). This means:
- If you enroll in the Plan, you will not be able to drop coverage for yourself or your dependents until the Annual Enrollment in 2012.
- If you elect not to enroll in the Plan or do not enroll an eligible spouse/child, you may not enroll until Annual Enrollment in 2012.

DEPENDENT INFORMATION

NAME FIRST, MIDDLE INITIAL, LAST		SEX	RELATIONSHIP	BIRTHDATE	STUDENT
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No

Are any dependent children adopted? ☐ Yes ☐ No If "yes," indicate name and date of adoption:
_____

Have you included stepchildren as dependents? ☐ Yes ☐ No If "yes," indicate name(s):
_____

Do your stepchildren reside with you? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No

I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make necessary deductions for the contributions, if any, required for insurance, or agree that the contributions be added to my dues; (3) state that I became an employee on the date stated above, and do currently work the number of hours per week stated above; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. Any person who, with intent to defraud or knowing that he 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. I have reviewed the statements on this application and they are true and complete.

SIGNATURE OF EMPLOYEE	DATE

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