



The Guardian Life Insurance Company of America

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

Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012

Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Form No. GG-011825
Group Enrollment Supplement/
Non-Medical Insurance

Planholder name (company name) Group Plan Number Branch

Planholder street address (city, state, zip)

Employee's name (Last, First, MI) Social Security # Birth Date

Employee's street address (city, state, zip) Telephone

Occupation/Job Title Date of Full-time Emp. Hours Worked Week Annual Salary \$

Marital Status Single Married Widowed Legally Separated Divorced Dependent children Yes No

ENROLLMENT FOR INSURANCE (Complete only for Guardian coverages desired.)

Employee coverage requested: Life/Accidental Death & Dismemberment, Life (plans without AD&D), Optional Life Amount \$, Dental, Short Term Disability, Long Term Disability.
Dependent coverage requested (Dependents cannot be enrolled for coverages declined by the employee.): Dependent Life, Optional Life Amount \$, Dental.
I elect dependent coverage for: spouse only, spouse & child(ren), child(ren) only

Give the following information for each dependent to be insured:

Table with 5 columns: Name (Last, /First, MI), Sex, Relationship, Birth Date, Student. Includes checkboxes for Yes/No for Student status.

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

EMPLOYEE BENEFICIARY DESIGNATION (Include full proper name and relationship; i.e.: Mary A. Jones, Wife.)

Name Relationship

ALTERNATIVE COVERAGE (Complete only if enrolling in a Dental Maintenance [DMO] Organization type plan.)

Name of DMO plan

REFUSAL OF INSURANCE (Complete only if not enrolling for all available Guardian coverages.)

If the plan requires contributions, and I have refused 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 that Guardian reserves the right to reject my request. However, I and my dependents will not be required to provide proof of insurability for major medical coverage if I and my dependents (a) are insured under the plan or policy listed below, and (b) provide documentation of that coverage and request enrollment in this plan within 30 days of the date that coverage terminates due to end of employment, death of a spouse, divorce, or where a court has ordered coverage be provided for a spouse or minor child.

I decline the following employee coverage/s available to me:

Life/Accidental Death & Dismemberment, Dental, Short Term Disability, Optional Life, Long Term Disability, Life (plans without AD&D), All Coverage

because: I am insured under another policy or group plan (please indicate information below) Other reasons

Employer's Name: Carrier Name:

I decline the following coverage/s available to my spouse only, spouse and child(ren), child(ren) only:

Dependent Life, Optional Life, Dental, All coverage

because: My dependents are insured under another policy or group plan (please indicate information below) Other reasons

Employer's Name: Carrier Name:

I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the 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 is guilty of insurance fraud.

I have reviewed the statements on this application and they are true and complete to the best of my knowledge and belief.

Signature of Employee, Signature of Witness, Date

FOR GUARDIAN USE ONLY (Indicate coverages and amounts.) Branch

Employee: Cert. No. Class Eff. Date Life (w/AD&D) Life (w/o AD&D) Optional Life

WLT SLT Dental

Dependent: Life Optional Life Dental