Enrollment / Change Form

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.

		Sex	Date of Birth (mm/dd/yyyy)			
☐ 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. ☐ Dental ☐ Vision

DENTAL — CHOOSE YOUR DENTAL COVERAGE: Check one box only

Find dental providers online at www.guardianlife.com or check the directory of providers.

	Option 1 – ________	Option 2 – ________	Option 3 - ________	
Employee Alone	☐	☐	☐	☐ I Waive This Coverage
Employee & Spouse	☐	☐	☐	☐ I Waive This Coverage
Employee & Child(ren)	☐	☐	☐	☐ I Waive This Coverage
Entire Family	☐	☐	☐	☐ I Waive This Coverage

If you or your family has lost dental coverage, please explain below. *Late entrant penalties may apply.*

Reason for Loss of coverage: Date of coverage loss:

☐ Termination of Employment. ☐ Divorce. ☐ Death of Spouse. ☐ Termination or Expiration of coverage

IMPORTANT NOTES:

- Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

VISION CHOOSE YOUR VISION COVERAGE: Check one box only

Find vision providers online at www.guardianlife.com or check the directory of providers.

	Option 1 – ___________	Option 2 –____________	
Employee Alone	☐	☐	☐ I Waive This Coverage
Employee & Spouse	☐	☐	☐ I Waive This Coverage
Employee & Child(ren)	☐	☐	☐ I Waive This Coverage
Entire Family	☐	☐	☐ I Waive This Coverage

IMPORTANT NOTES:

- Proof of insurability does not apply to vision, but if you waiver vision coverage and later decide to enroll, you may be subject to delays in enrollment.

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 my dependent(s) cannot be enrolled for coverage if I am not enrolled for that coverage.
- 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