GUARDIAN®

The Guardian Life Insurance Company of America
The Guardian Insurance & Annuity Company, Inc.

☐ Guardian Life Insurance Company of America
Northeast Regional Office
Attn: GUL Unit, LGFS, 3N
P.O. Box 26075
Lehigh Valley, PA 18002-6075

☐ Guardian Life Insurance Company of America
Midwest Regional Office
Attn: GUL Unit
P.O. Box 8012
Appleton, WI 54912-8012

GG-013500NY
Enrollment Form
For Non-Medical Coverages

Planholder Name (Company Name)	Group Plan No.	Division	Class

Planholder Street Address	City	State	Zip

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

PLEASE CHECK REASON FOR COMPLETING: ☐ **INITIAL APPLICATION**

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

☐ **PREMIUM CLASS** ☐ **DEATH BENEFIT OPTION (GUL ONLY)**

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

GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED

Name (Last, First, Middle Initial)	Sex	Birthdate	Employee's Social Security #
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):
(3) Are they dependent on you for support and maintenance? ☐ Yes ☐ No

Date of Full Time Employment	Hrs. Worked / Week	Annual Salary	Occupation /Job Title
		$	

Employee's Street Address	City

State	Zip	Business Phone #	Home Phone #

Beneficiary Name (Last, First, Middle),Relationship and % _____ ____%

Beneficiary Name (Last, First, Middle),Relationship and % _____ ____%

Have you or your spouse used any form of tobacco in the past 6 months (e.g., pipe, chewing tobacco) or smoked cigarettes in the past 12 months?

Employee ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No *If "yes", specify:* Type: Amount Used:

In the last 6 months, have you or any of your dependents: (a) (excluding HIV), received medical treatment, consultation, care or services, including diagnostic measures or took prescribed drugs for: cardiovascular disease; cancer or any other life threatening condition?; or (b) been treated for (including prescription drugs) or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex?

Employee ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child(ren)** ☐ Yes ☐ No

AN EVIDENCE OF INSURABILITY FORM(S) MUST BE COMPLETED FOR ANY EMPLOYEE OR DEPENDENT(S) WITH A "YES" ANSWER TO THE ABOVE QUESTION.

BASIC LIFE with Accidental Death & Dismemberment

Employee: ☒ Coverage has been paid for you by your company (in the amount of $) if you meet eligibility requirements.

VOLUNTARY TERM LIFE

Employee:
☐ **$25,000**
☐ **$50,000**
☐ **$75,000**
☐ **$100,000**

Spouse: (50% of emp amt to $50,000)
☐ **Yes** ☐ **No***

Child(ren): (10% of emp amt to $10,000)
☐ **Yes** ☐ **No***
(Less than 14 days is not covered)

☐ **I decline coverage. * (this also waives dependent coverage).**

SHORT TERM DISABILITY

Employee: ☒ Coverage has been paid for you by your company if you meet eligibility requirements.

Employee: ☐ **I elect coverage.** ☐ **I decline coverage.***

SHORT TERM DISABILITY (Flex Ability Guard)

Employee: ☐ **$100** ☐ **$150** ☐ **$200** ☐ **$250** ☐ **$300** ☐ **$400** ☐ **$500** ☐ **I decline coverage.***

LONG TERM DISABILITY

Employee: ☒ Coverage has been paid for you by your company if you meet eligibility requirements.

Employee: ☐ I elect coverage. ☐ I decline coverage.*

DENTAL

Employee: **Spouse:** **Child(ren):**

☐ **I elect coverage.** ☐ **Yes** ☐ **No***** ☐ **Yes** ☐ **No*****

☐ **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

☐ **Employee****
☐ **Employee & Spouse*****
☐ **Employee & Child(ren)*****
☐ **Employee, Spouse & Child(ren)*****

☐ **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

VISION

Employee: **Spouse:** **Child(ren):**

☐ **I elect coverage.** ☐ **Yes** ☐ **No***** ☐ **Yes** ☐ **No*****

☐ **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 vision plan? ☐ Yes ☐ No

*** If declining dependent coverage, are your dependents covered under another vision plan? ☐ Yes ☐ No

☐ **Employee****
☐ **Employee & Spouse*****
☐ **Employee & Child(ren)*****
☐ **Employee, Spouse & Child(ren)*****

☐ **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 vision plan? ☐ Yes ☐ No

*** If declining dependent coverage, are your dependents covered under another vision plan? ☐ Yes ☐ No

BASIC LIFE WITH ENHANCED ACCIDENTAL DEATH & DISMEMBERMENT

Employee: ☐ I elect coverage. ☐ I decline coverage.*

VOLUNTARY TERM LIFE WITH ENHANCED ACCIDENTAL DEATH & DISMEMBERMENT

Employee Life:
$_____
☐ **I decline coverage. ***

AD&D Employee
☐ **$50,000** ☐ **$100,000** ☐ **$150,000** ☐ **$200,000**
☐ **$250,000** ☐ **$300,000** ☐ **$350,000** ☐ **$400,000**
☐ **$450,000** ☐ **$500,000**
☐ **I decline coverage. ***

Spouse Life:
$_____
☐ **I decline coverage. ***

Child(ren) Life: **(1-13 days not covered)**
$_____ **(14 days-6 months is a $500 benefit)**
☐ **I decline coverage. ***

Family AD&D (Includes Spouse and Child(ren)) ☐ Yes ☐ No *

ENHANCED ACCIDENTAL DEATH & DISMEMBERMENT

Employee AD&D: ☐ **$50,000** ☐ **$100,000** ☐ **$150,000** ☐ **$200,000** ☐ **$250,000** ☐ **$300,000** ☐ **$350,000** ☐ **$400,000** ☐ **$450,000** ☐ **$500,000**
☐ **I decline coverage. ***

Family AD&D (Includes Spouse and Child(ren)): ☐ **Yes** ☐ **No ***

GUARDIAN'S UNIVERSAL LIFE: Issued by: The Guardian Insurance & Annuity Company, Inc. (GIAC)

Insurance Amount $_____
Death Benefit Option: ☐ Level ☐ Increasing
Employee Accidental Death $_____
Spouse Term $_____
Child(ren) Term $_____

☐ Current 20 Pay _____
☐ Current Level _____
☐ Minimum _____
☐ Other _____

Quoted Premium Frequency:
☐ Weekly ☐ Semi-Monthly
☐ Bi-Weekly ☐ Monthly

Will Guardian's Universal Life insurance replace any existing life insurance or annuity? ☐ Yes ☐ No If yes, please provide the following:
Existing insurer and insured: Policy number: Amount of insurance:

Declination of Guardian's Universal Life*: ☐ **Employee** ☐ **Spouse** ☐ **Child(ren)**

PLEASE READ AND SIGN THE SIGNATURE SECTION ON THE REVERSE SIDE OF THIS FORM

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 coverage will not take effect and my life 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 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.
- **NAIC Quotation:** By signing this enrollment form, I certify that I received no illustration in the sale of Guardian's Universal Life insurance. I understand that an

X **SIGNATURE OF EMPLOYEE**	**DATE**

LICENSED REPRESENTATIVE STATEMENT AND SIGNATURE ***(applies to Guardian's Universal Life Only)***

I certify that no illustration was used in the sale of Guardian's Universal Life insurance. To the best of your knowledge, will this insurance replace any existing life insurance or annuity? ☐ Yes ☐ No

x SIGNATURE OF LICENSED REPRESENTATIVE	**CODE**	**STATE WHERE APPLICANT SIGNED:**

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