



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
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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: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy)	Social Security Number
Address		City	State	Zip
The best way to reach you: <input type="checkbox"/> Day Phone <input type="checkbox"/> Evening Phone <input type="checkbox"/> Email		Business Phone#	Home Phone #	Preferred Email
Job Title:	Work Status/Eligibility: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> 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.

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

DENTAL CHOOSE YOUR DENTAL COVERAGE: Check one box only

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

Employee Alone <input type="checkbox"/>	<input type="checkbox"/> I Waive This Coverage
Employee & Spouse <input type="checkbox"/>	<input type="checkbox"/> I Waive This Coverage
Employee & Child(ren) <input type="checkbox"/>	<input type="checkbox"/> I Waive This Coverage
Entire Family <input type="checkbox"/>	<input type="checkbox"/> 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.

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