



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

**GG-013500NY**  
**Enrollment Form**  
**For Non-Medical Coverages**

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

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:	<input type="checkbox"/> M <input type="checkbox"/> F		
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F		Date of Marriage / /
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> 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:  I elect coverage.  I decline coverage. I understand if I elect coverage at a later date, late entrant penalties will apply. \*\*  
Spouse:  Yes  No\*\*\* Child(ren):  Yes  No\*\*\*

\*\* 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:  I elect coverage.  I decline coverage. I understand if I elect coverage at a later date, late entrant penalties will apply. \*\*  
Spouse:  Yes  No\*\*\* Child(ren):  Yes  No\*\*\*

\*\* 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: \$ \_\_\_\_\_ Spouse Life: \$ \_\_\_\_\_ Child(ren) Life: \$ \_\_\_\_\_ (1-13 days not covered)  
AD&D Employee  I decline coverage. \*  I decline coverage. \*  I decline coverage. \* (14 days-6 months is a \$500 benefit)  
 \$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 \*

**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 \$ \_\_\_\_\_ Quoted Premium Frequency:  
Death Benefit Option:  Level  Increasing  Current 20 Pay \_\_\_\_\_  Weekly  Semi-Monthly  
Employee Accidental Death \$ \_\_\_\_\_  Current Level \_\_\_\_\_  Bi-Weekly  Monthly  
Spouse Term \$ \_\_\_\_\_  Minimum \_\_\_\_\_  
Child(ren) Term \$ \_\_\_\_\_  Other \_\_\_\_\_

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

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