



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

Northeast Regional Office
PO Box 26040
Lehigh Valley PA 18002-6040

Bridgewater Office
PO Box 425
E. Bridgewater MA 02333-0425

Western Regional Office
PO Box 2454
Spokane WA 99210-2454

**Enrollment Form
For Non-Medical Coverages**

Planholder Name (Company Name) Simple HR				Group Plan No.		Division		Class		
Planholder Street Address					City			State	Zip	
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> INITIAL APPLICATION CHANGE: <input type="checkbox"/> INCREASE <input type="checkbox"/> ADD DEPENDENT(S)/RIDER(S) <input type="checkbox"/> PREMIUM CLASS										
GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED										
Name (Last, First, Middle Initial)					Sex	Birthdate		Employee Social Security #		
Employee:					<input type="checkbox"/> M <input type="checkbox"/> F					
Are you <input type="checkbox"/> Actively at work <input type="checkbox"/> Retired										
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed							Dependent Children: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of Marriage:										
Date of Full Time Employment		Hrs. Worked / Week	Annual Salary \$	Occupation / Job Title			Beneficiary(s)			
							Name (Last, First, Middle)	Relationship	%	
Employee's Street Address			City		State	Zip	Name (Last, First, Middle)	Relationship	%	
Business Phone #		Home Phone #		Email Address						
Name (Last, First, Middle Initial)					Sex	Birthdate		Dependent Social Security #		
Spouse:					<input type="checkbox"/> M <input type="checkbox"/> F					
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F					
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F					
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F					
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> M <input type="checkbox"/> F					
(1) Are any dependent children adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate name and date of placement:										
(2) Have you included stepchildren? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate name(s): Are they dependent on you for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No										
(3) Do any dependents reside at a different address than indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate name and address:										
(4) Do any dependent children have a mental or physical handicap or developmental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" indicate name(s):										

Please remember:

- The standard waiting time for these benefits is 90-days to first day of the following month.
- Please complete this application and forward to Simple HR (Fax: 850-650-9936).
- You must elect or decline participation in the benefits offered on the reverse side of this form.
- Your deductions will always begin 30-days prior to your effective date of coverage.
- Please sign and date your application.

VISION COVERAGE ELECTION:	Issued by: The Guardian Life Insurance Company of America
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- Employee
 Employee + ONE Dependent (One Child or Spouse)
 Employee + TWO OR MORE Dependents (Family or Children)
 I decline coverage for Employee Spouse Child(ren). 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

DENTAL COVERAGE ELECTION:	Issued by: The Guardian Life Insurance Company of America
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- Employee High Option
 Spouse Low Option
 Child(ren)
 I decline coverage for Employee Spouse Child(ren). 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

- I hereby apply for the group benefit(s) indicated above.
- I understand I must be actively at work or 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 life 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 knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

X SIGNATURE OF EMPLOYEE	DATE
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PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN