



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

- Midwest Regional Office  
P.O. Box 8012  
Appleton, WI 54912-8012
  Northeast Regional Office  
P.O. Box 26040  
Lehigh Valley, PA 18002-6040
  Norwell Regional Office  
P.O. Box 9121  
Norwell, MA 02061-9121
  Western Regional Office  
P.O. Box 2454  
Spokane, WA 99210-2454

**GG-013499**  
**Enrollment Form**  
**For Non-Medical Coverages**

Planholder Name (Company Name) <b>Engineers &amp; Architects, Inc.</b>		Group Plan No.	Division	Class
Planholder Street Address		City	State	Zip
<b>MARITAL STATUS:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced				
<b>PLEASE CHECK REASON FOR COMPLETING:</b> <input type="checkbox"/> INITIAL APPLICATION <b>CHANGE:</b> <input type="checkbox"/> ADD DEPENDENT(S) <input type="checkbox"/> TERMINATE A FAMILY MEMBER <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME <input type="checkbox"/> DELETE COVERAGE <b>DATE OF CHANGE</b> ___/___/___ <b>REASON FOR CHANGE</b> _____				
<b>GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED</b>				
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? <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): (3) Are they dependent on you for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 #	
<b>DENTAL</b>				
<input type="checkbox"/> Employee**		<b>*Dental Ofc. #</b>		
<input type="checkbox"/> Spouse***	<input type="checkbox"/> PPO	<input type="checkbox"/> Pre-Paid * CA EE	_____ Employee	
<input type="checkbox"/> Child(ren)***		only	_____ Spouse	
			_____ Child(ren)	
<input type="checkbox"/> I decline coverage for: <input type="checkbox"/> Employee. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I decline coverage for: <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) I understand if I elect coverage at a later date, late entrant penalties will apply. ** *** If declining dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>DECLINATION OF COVERAGE:</b>				
* 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.				
<ul style="list-style-type: none"> <li>I hereby apply for the group benefit(s) indicated above.</li> <li>I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service.</li> <li>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.</li> <li>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.</li> <li>The information provided above is true and correct to the best of my knowledge.</li> <li>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.</li> </ul>				
X SIGNATURE OF EMPLOYEE				DATE

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