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

GG-013500
Enrollment Form
For Non-Medical Coverages

☐ Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012
☐ Northeast Regional Office, P.O. Box 26040, Lehigh Valley, PA 18002-6040
☐ Bridgewater Office, P.O. Box 425, E. Bridgewater, MA 02333-0425
☐ Western Regional Office, P.O. Box 2454, Spokane, WA 99210-2454

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

Planholder Street Address	City	State	Zip

PLEASE CHECK REASON FOR COMPLETING: ☐ INITIAL APPLICATION CHANGE: ☐ INCREASE ☐ ADD DEPENDENT(S)/RIDER(S) ☐ PREMIUM CLASS ☐ DEATH BENEFIT OPTION (GUL ONLY)

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

(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): 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(s):

_______________ _______________ ___%
Name (Last, First, MI) Relationship

_______________ _______________ ___%
Name (Last, First, MI) Relationship

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 received medical treatment, consultation, care or services, including diagnostic measures or took prescribed drugs for: cardiovascular disease; cancer; any condition related to Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex; or any other life threatening condition? **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.

OPTIONAL TERM LIFE: Issued by: The Guardian Life Insurance Company of America

Employee Life: $__________ Spouse Life: $__________ Child(ren) Life: $__________ (1-13 days not covered)

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 $__________

Basic Certificate Premium $__________ (Includes Extra Dollar? ☐ Yes)
Rider(s): Accidental Death $__________
Spouse Term $__________
Child(ren) Term $__________
Total Designated Premium $__________

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 COVERAGE*:* I hereby waive the following coverage(s):
Optional Term Life: ☐ Myself ☐ Spouse ☐ Child(ren) **Guardian's Universal Life:** ☐ Myself ☐ Spouse ☐ Child(ren)
If I have waived the life 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 life coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service.
- 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 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 illustration conforming to the coverage as issued will be provided no later than at the time of certificate delivery.

✕ 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

✕ SIGNATURE OF LICENSED REPRESENTATIVE CODE STATE WHERE APPLICANT SIGNED: