

Planholder Name (Company Name)		Group Plan No. <b>392021</b>	Division	Class
Planholder Street Address		City	State	Zip

MARITAL STATUS  
 Single    Married    Widowed    Legally Separated    Divorced

DEPENDENT CHILD(REN)  
 Yes    No

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:	<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

(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	Beneficiary Name (Last, First, Middle), Relationship and % _____ %
Employee's Street Address			City	_____ %
State	Zip	Business Phone #	Home Phone #	

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**, has your spouse 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?  
**Spouse**  Yes    No  
**AN EVIDENCE OF INSURABILITY FORM(S) MUST BE COMPLETED FOR ANY SPOUSE WITH A "YES" ANSWER TO THE ABOVE QUESTION.**

**GUARDIAN'S UNIVERSAL LIFE:** Issued by: The Guardian Insurance & Annuity Company, Inc. (GIAC)

Insurance Amount   \$ _____	Basic Certificate Premium   \$ _____ (Includes Extra Dollar? <input type="checkbox"/> Yes)
Death Benefit Option: <input type="checkbox"/> Level <input type="checkbox"/> Increasing	Rider(s):   Accidental Death   \$ _____ <b>Quoted Premium Frequency:</b>
Employee Accidental Death   \$ _____	Spouse Term   \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Semi-Monthly
Spouse Term   \$ _____	Child(ren) Term   \$ _____ <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly
Child(ren) Term   \$ _____	<b>Total Designated Premium</b> \$ _____

**Declination of Guardian's Universal Life\*:**    Myself    Spouse    Child(ren)

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:**  
\*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.

**X 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

**X SIGNATURE OF LICENSED REPRESENTATIVE** \_\_\_\_\_   **STATE WHERE APPLICANT SIGNED:** \_\_\_\_\_