

ENROLLMENT FORM FOR NON-MEDICAL COVERAGES

EMPLOYER NAME:		BUSINESS PHONE: () - x		ORG ID (Account number):	
1. EMPLOYEE NAME (Last, First, Middle Initial):		2. SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		3. SOCIAL SECURITY NUMBER:	
4. EMPLOYEE ADDRESS (Number and Street):		5. CITY:		6. STATE:	
				7. ZIP CODE:	
				8. PHONE NUMBER: () -	
9. DATE OF BIRTH / /		10. DATE OF HIRE: / /		11. SALARY <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly <input type="checkbox"/> Annually	
				12. HOURS WORKED WEEKLY:	
13. JOB TITLE:		14. WORK STATUS: Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. WORK DUTIES: Are you able to perform the duties of your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				16. EFFECTIVE DATE: / /	

COVERAGE SELECTION(S): Your employer will inform you of available coverages: LATE APPLICANT

LIFE INSURANCE OPTIONS			
<input type="checkbox"/>	Life / AD&D	<input type="checkbox"/> Add <input type="checkbox"/> Delete	
<input type="checkbox"/>	Dependent Life	<input type="checkbox"/> Add <input type="checkbox"/> Delete	
<input type="checkbox"/>	Supplemental Life	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete	AMOUNT: \$ _____
VOLUNTARY DISABILITY INSURANCE OPTIONS			
<input type="checkbox"/>	Short Term Disability Plan: _____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete	BENEFIT AMOUNT: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
<input type="checkbox"/> I decline coverage. If I request coverage 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.			
<input type="checkbox"/>	Long Term Disability Plan: _____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete	BENEFIT AMOUNT: \$ _____/month PREMIUM AMOUNT: \$ _____
<input type="checkbox"/> I decline coverage. If I request coverage 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.			
In the past two years, have you missed 5 or more consecutive work days for a sickness, injury or chronic condition other than a cold or flu? <input type="checkbox"/> YES <input type="checkbox"/> NO In the past two years, have you missed more than 10 days, in total, due to a single sickness, injury or chronic condition? <input type="checkbox"/> YES <input type="checkbox"/> NO If you responded "yes" to either of the above, please provide details.			

BENEFICIARY DESIGNATION: Must be completed. If you have additional beneficiaries, please attach a separate sheet. Change in Beneficiary

NAME:	DATE OF BIRTH:	SOCIAL SECURITY #:	RELATIONSHIP:	BENEFIT %:
PRIMARY: <input type="checkbox"/> Life <input type="checkbox"/> Disability				
PRIMARY: <input type="checkbox"/> Life <input type="checkbox"/> Disability				
CONTINGENT BENEFICIARY: <i>(used only if the above beneficiary dies before you do)</i>				

I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature also verifies the accuracy of the information on this form. If I have declined all or portions of coverage, I understand that any request to change this decision may not be approved unless I provide satisfactory evidence of insurability.

NOTICE: Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet.

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 until I have completed a waiting period (as defined in the Group Plan) of full time service.
- 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.

Employee Signature _____ Date ____/____/____ GRD-EF 3/06