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

GG-013500
Enrollment Form
For Non-Medical Coverage

Planholder Name: (Company Name)	Group Plan No.	Division:	Class:
RETIREE ASSOCIATION	421887		
Planholder Street Address: 28350 Kensington Ln., Ste 100	City: Perrysburg	State: OH	Zip: 43551

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

PLEASE CHECK REASON FOR COMPLETING: ☐ INITIAL APPLICATION

CHANGE: ☐ ADD DEPENDENT(S) ☐ TERMINATE A FAMILY MEMBER ☐ ADDRESS ☐ NAME ☐ DELETE COVERAGE

DATE OF CHANGE ____/____/____ REASON FOR CHANGE: ______________________________

GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED (Name (Last, First, Middle Initial)	Sex	Birthdate	Social Security #
Employee:	☐M ☐F		
Spouse:	☐M ☐F		
		Date of Marriage:	

Employee's Street Address:			City:
State:	Zip:	Business Phone #:	Home Phone #:

DENTAL

☐ **Employee**** ☐ **Employee & Spouse***** ☐ **Family*****

☐ **I decline coverage**. 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

VISION

☐ **Employee**** ☐ **Employee & Spouse***** ☐ **Family*****

☐ **I decline coverage**. 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

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 and insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

X SIGNATURE OF EMPLOYEE	DATE

** PLEASE SUBMIT APPLICATION ALONG WITH ANNUAL PREMIUM TO:

CEF - 1999

BUTLER CAPITAL ADVISORS
Attn: Retiree Enrollment Department
28350 Kensington Ln., Suite 100
Perrysburg, OH 43551
Phone: (800) 357-3190 or (419) 243-9665 Fax: (419) 243-2695