



MEMBER ENROLLMENT FORM

EBD187



PLEASE USE BLOCK LETTERS WHEN COMPLETING THIS FORM

| FOR EMPLOYER USE | | | |
|-----------------------|-----------------|--|-----------|
| EMPLOYER/COMPANY NAME | | | |
| GROUP No. | Div. No. | | |
| | | | |
| LOCATION | EMPLOYMENT DATE | | INS CLASS |
| | DD | MM | YY |
| | | | |
| EFFECTIVE DATE * | | NEW HIRE: Y <input type="checkbox"/> N <input type="checkbox"/> | |
| DD | MM | YY | |
| | | | |
| | | OPEN ENROLLMENT: Y <input type="checkbox"/> N <input type="checkbox"/> | |
| REMARKS: | | | |

| | | | |
|-------------------------|--|---|----------------------------------|
| MEMBER No. ¹ | MEMBER/EMPLOYEE NAME (LAST NAME, ³ FIRST NAME, ³ MIDDLE INITIAL ³) | | |
| | | | |
| DATE OF BIRTH | SEX | | MARITAL STATUS |
| DD MM YY | M | F | <input type="checkbox"/> SINGLE |
| | | | <input type="checkbox"/> MARRIED |
| | OCCUPATION | | |
| | | | |
| TRN ² | HOW DO YOU PREFER TO BE CONTACTED? | | PHONE NUMBER |
| | <input type="checkbox"/> E-mail <input type="checkbox"/> Phone | | Home |
| | E-mail Address: | | Cell. |
| | | | |

| LAST NAME (If Different) | DEPENDENTS | | RELATIONSHIP TO EMPLOYEE | SEX | | DATE OF BIRTH | | | TRN |
|--------------------------|------------|------|--------------------------|-----|---|---------------|-----|----|-----|
| | FIRST | M.I. | | M | F | DAY | MO. | YR | |
| | | | | | | | | | |
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| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

| BENEFITS ELECTED | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> MEDICAL <input type="checkbox"/> EE Only <input type="checkbox"/> DEP (S) Incl. | <input type="checkbox"/> DENTAL <input type="checkbox"/> EE Only <input type="checkbox"/> DEP (S) Incl. | <input type="checkbox"/> OPTICAL <input type="checkbox"/> EE Only <input type="checkbox"/> DEP (S) Incl. | <input type="checkbox"/> DENTAL/OPTICAL <input type="checkbox"/> EE Only <input type="checkbox"/> DEP (S) Incl. | <input type="checkbox"/> OTHER <input type="checkbox"/> EE Only <input type="checkbox"/> DEP (S) Incl. |

As provided under my Employer's Group Contract with Guardian Life Limited, I elect coverage as indicated above on behalf of myself and my eligible dependent(s) as listed above (where applicable) and authorize my employer to deduct from my earnings the contributions required (if any) for the benefits elected.

Having elected a Medical, Dental and/or Optical Plan, I authorize Guardian Life Limited to have access to, and copies of, all medical, Hospital or other institution/agency records relating to the diagnosis, treatment or services provided to me or a covered dependent.

I certify that the above information is correct to the best of my knowledge and confirm that I understand the conditions as stated above.

* I understand that the Effective Date of this insurance is subject to (a) my being actively at work on the day in question; (b) the rules and conditions of the company's underwriters as set forth in the Group Insurance Contract.

SIGNATURE OF EMPLOYEE: _____ DATE: _____
(If employee is applying for coverage outside of eligibility period, please complete the Health History Questionnaire)