

The Guardian Life Insurance Company of America

Midwest Regional Office
 P.O. Box 8012
 Appleton, WI 54912-8012

GG-013499VA
Enrollment Form
For Non-Medical Coverages

Planholder Name (Company Name) University of Virginia Housestaff Physicians				Group Plan No. 285129	
Planholder Street Address Jefferson Park Avenue, McKim Hall			City Charlottesville		State VA
					Zip 22901
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced				DEPENDENT CHILDREN: <input type="checkbox"/> YES <input type="checkbox"/> NO	
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> INITIAL APPLICATION CHANGE: <input type="checkbox"/> INCREASE <input type="checkbox"/> ADD DEPENDENT(S)					
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		
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 #	_____ %	
BASIC LIFE					
<input checked="" type="checkbox"/> Coverage has been paid for you by your company in the amount of 1.5 X's your annual salary, if you meet eligibility requirements.					
<ul style="list-style-type: none"> 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 and 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 is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law. 					
<input checked="" type="checkbox"/> SIGNATURE OF EMPLOYEE					DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN

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