GUARDIAN®

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

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

☐ Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040

☐ **Bridgewater Office**
P.O. Box 425
E. Bridgewater, MA
02333-0425

☐ Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

GG-013499NY
Enrollment Form
For Non-Medical Coverages

Planholder Name (Company Name)	Group Plan No.	Division	Class
The Churchill Benefit Corporation bda Yurcor	**00358888**		

Planholder Street Address	City	State	Zip
150 East Palmetto Park Road, #505	**Boca Raton**	**Florida**	**33432**

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	Employee's Social Security #
Employee:	☐ M ☐ F		
Spouse:	☐ M ☐ F		Date of Marriage / /
Child:	☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
Child:	☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
(1) Are any dependent children adopted? ☐ Yes ☐ No If "yes", indicate name and date of placement:	☐ M ☐ F		Full Time Student? ☐ Yes ☐ No
	☐ M ☐ F		Full Time Student? ☐ Yes ☐ No

Date of Full Time Employment	Hrs. Worked / Week	Annual Salary	Occupation /Job Title
		$	

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

Beneficiary Name (Last, First, Middle),Relationship and %

_____%

Beneficiary Name (Last, First, Middle),Relationship and %

_____ _____%

BASIC LIFE with Accidental Death & Dismemberment

Employee: ☐ **I elect coverage**

LONG TERM DISABILITY

Employee: ☐ **I elect coverage.**

DENTAL

Employee:	**Spouse:**	**Child(ren):**
☐ **I elect coverage.**	☐ **Yes** ☐ **No***	☐ **Yes** ☐ **No***

☐ **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

VISION

Employee:	**Spouse:**	**Child(ren):**
☐ **I elect coverage**	☐ **Yes**	☐ **Yes**
☐ **I decline coverage.**		

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 and my life coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
- 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.

X **SIGNATURE OF EMPLOYEE**	**DATE**