



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

GG-013500WI
Enrollment Form
For Non-Medical Coverages

Planholder Name (Company Name) ACES Xavier Educational System		Group Plan No. 430243	
Planholder Street Address 101 E. Northland Avenue		City Appleton	State WI
		Zip 54911	
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed			
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> NEWLY ELIGIBLE <input checked="" type="checkbox"/> OPEN ENROLLMENT			
GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED			
Name (Last, First, Middle Initial)		Sex	Birthdate
Employee:		<input type="checkbox"/> M <input type="checkbox"/> F	Employee's Social Security #
Spouse:		<input type="checkbox"/> M <input type="checkbox"/> F	Date of Marriage / /
Child:		<input type="checkbox"/> M <input type="checkbox"/> F	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> M <input type="checkbox"/> F	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> M <input type="checkbox"/> F	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
(1) Are any dependent children adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name and date of placement:			
(2) Have you included stepchildren? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name(s):			
(3) Are they dependent on you for support and maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of Full Time Employment		Hrs. Worked / Week	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: <input checked="" type="checkbox"/> Coverage has been paid for you by your company if you meet eligibility requirements.			
Dependents: <input checked="" type="checkbox"/> Coverage has been paid for you by your company if you meet eligibility requirements.			
LONG TERM DISABILITY			
Employee: <input checked="" type="checkbox"/> Coverage has been paid for you by your company if you meet eligibility requirements.			
DENTAL			
I elect coverage:		Type of coverage:	
<input type="checkbox"/> Base Plan		<input type="checkbox"/> Employee Only**	
<input type="checkbox"/> Buy-Up Plan		<input type="checkbox"/> Employee + 1 Dependent***	
		<input type="checkbox"/> Full Family***	
<ul style="list-style-type: none"> • Enrollment is limited to annual open enrollment periods, as designated by your Employer. • Exception can be granted if you experience a qualifying event. 			
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
*** If declining dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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.			
<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 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. 			
X SIGNATURE OF EMPLOYEE			DATE