GUARDIAN®

Employer:
Reliable Heating & Air LLC
4681 Canton Rd
Marietta, GA 30066

Guardian Group Plan Number: **00447340**

The Guardian Life Insurance Company of America

EMPLOYER USE ONLY ☐ New Application ☐ Add Dependent(s) ☐ Drop Dependent(s) ☐ Change Address ☐ Change Name ☐ Drop Coverage as of: / /

Class	Hours Worked	Division	Benefits Effective
1			/ /

Keep a copy for your records and return form to: **Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012**

V1.5 E 0001 00447340 key*

ABOUT YOURSELF

Print clearly in black or blue ink.

First, Middle Initial, Last Name ☐ Add ☐ Change ☐ Drop	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	Social Security Number
		/ /	- -

Address	City	State	Zip

Preferred E-mail	Day Phone	Eve Phone	The best way to reach you: ☐ E-mail ☐ Day Phone ☐ Eve Phone

Job Title	Work Status ☐ Full-Time ☐ Part-Time ☐ Retired ☐ COBRA/State Continuation	Date work status began	Annual Salary/Earnings
		/ /	$

Are you married? ☐ Yes ☐ No

Do you have children or other dependents? ☐ Yes ☐ No

ABOUT YOUR DEPENDENTS

A sheet with information about additional dependents is attached.

	Sex	Date of Birth (mm/dd/yyyy)	Social Security Number	Marriage Date	
Spouse First, Middle Initial, Last Name ☐ Add ☐ Change ☐ Drop	☐ M ☐ F	/ /	- -	/ /	
Child 1 ☐ Add ☐ Change ☐ Drop	☐ M ☐ F	/ /	☐ Full-time student, at (school):	City/State:	Attending Since / /
Child 2 ☐ Add ☐ Change ☐ Drop	☐ M ☐ F	/ /	☐ Full-time student, at (school):	City/State:	Attending Since / /
Child 3 ☐ Add ☐ Change ☐ Drop	☐ M ☐ F	/ /	☐ Full-time student, at (school):	City/State:	Attending Since / /
Child 4 ☐ Add ☐ Change ☐ Drop	☐ M ☐ F	/ /	☐ Full-time student, at (school):	City/State:	Attending Since / /

To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages.
☐ Voluntary Life

CHOOSE YOUR VOLUNTARY TERM LIFE COVERAGE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) *Check one box only*

Employee	**Policy Amount**	You must be enrolled to cover your dependents.
	☐ **$50,000***	
	**Guarantee Issue Amount*	
☐ I waive this coverage		

Add Voluntary Life for Spouse	*Check one box only*
	☐ 50% of employee's amount to maximum $25,000
☐ I waive this coverage	***The amount may not be more than 50% of the employee amount for Voluntary Life.***

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Apr 03, 2009

LIFE INSURANCE *continued*

Add Voluntary Life for Child(ren)	*Check one box only*
	☐ 10% of employee's amount to maximum $5,000
☐ I waive this coverage	***The amount may not be more than 10% of the employee amount for Voluntary Life.***

Name your beneficiaries		Primary beneficiaries must total 100%.
Primary Beneficiary 1 First, Middle Initial, Last Name	Relationship to Employee	Percent %
Primary Beneficiary 2		%
Contingent Beneficiary		%
In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.		

For Voluntary Life, an Evidence of Insurability form must be completed for any amount above the Guarantee Issue.

IMPORTANT NOTES

If you waive life or disability coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian reserves the right to reject your request.
Children will not be covered until they reach 14 days.

Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Voluntary Life and/or Guardian Universal Life.

SIGNATURE

I hereby apply for the group benefit(s) that I have chosen above.
I understand that I must meet eligibility requirements for all coverages that I have chosen above.
I understand that I must be actively at work or my life and/or disability 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 my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.

I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
I understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
I attest that 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.

SIGNATURE OF EMPLOYEE X _____ **DATE** _____