The Guardian Life Insurance Company of America
Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040

GG-013500
Enrollment Form
For Non-Medical Coverages

Planholder Name (Company Name)	Group Plan No.	Division	Class
Messiah College	00414842		

Planholder Street Address	City	State	Zip
One College Avenue, PO Box 3015	Grantham	PA	17027

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced **DEPENDENT CHILDREN:** ☐ YES ☐ NO

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
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:
(2) Have you included stepchildren? ☐ Yes ☐ No If "yes", indicate name(s):
(3) Are they dependent on you for support and maintenance? ☐ Yes ☐ No

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

Employee's Street Address	City

State	Zip	Business Phone #	Home Phone #

DENTAL

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

*** If declining dependent coverage, are your dependents covered under another dental plan? ☐ **Yes** ☐ **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.

- 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

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