



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

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

GG-013500
Enrollment Form
For Non-Medical Coverages

Planholder Name (Company Name) Oldham County Fiscal Court		Group Plan No. 380657		Division	Class
Planholder Street Address			City	State	Zip
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced					
PLEASE CHECK REASON FOR COMPLETING: <input type="checkbox"/> INITIAL APPLICATION					
CHANGE: <input type="checkbox"/> ADD DEPENDENT(S) <input type="checkbox"/> TERMINATE A FAMILY MEMBER <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME <input type="checkbox"/> 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:		<input type="checkbox"/> M <input type="checkbox"/> F			
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	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 % _____ %		
In the last 6 months, have you or any of your dependents received medical treatment, consultation, care or services, including diagnostic measures or took prescribed drugs for: cardiovascular disease; cancer; any condition related to Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex; or any other life threatening condition? Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No					
AN EVIDENCE OF INSURABILITY FORM(S) MUST BE COMPLETED FOR ANY EMPLOYEE OR DEPENDENT(S) WITH A "YES" ANSWER TO THE ABOVE QUESTION.					
BASIC LIFE with Accidental Death & Dismemberment					
Employee: <input checked="" type="checkbox"/> Coverage has been paid for you by your company in the amount of \$20,000, if you meet eligibility requirements.					
VOLUNTARY TERM LIFE					
Employee: (You may elect coverage in \$10,000 increments, ranging from \$10,000 - \$150,000)		Spouse: (50% of emp amt to \$50,000)		Child(ren): (10% of emp amt to \$10,000)	
<input type="checkbox"/> I elect \$_____ of coverage.		<input type="checkbox"/> Yes <input type="checkbox"/> No*		<input type="checkbox"/> Yes <input type="checkbox"/> No* (Less than 14 days is not covered)	
<input type="checkbox"/> I decline coverage. * (this also waives dependent coverage).					
VOLUNTARY DENTAL:					
Please elect one option: <input type="checkbox"/> I elect Plan 1. <input type="checkbox"/> I elect Plan 2.					
Please elect one option: <input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse*** <input type="checkbox"/> Employee & Child(ren)*** <input type="checkbox"/> Employee & Family***					
<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	