



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) The Churchill Benefit Corporation dba Yurcor		Group Plan No. 00 358888	Division	Class
Planholder Street Address 100 East Linton Blvd., Ste 401A		City Delray Beach	State Florida	Zip 33483
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 %		
_____ %		_____ %		
BASIC LIFE with Accidental Death & Dismemberment (employer paid)				
Employee: <input type="checkbox"/> I elect coverage				
LONG TERM DISABILITY (employer paid)				
Employee: <input type="checkbox"/> I elect coverage.				
DENTAL	Employee: <input type="checkbox"/> I elect coverage.	Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No***	Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No***	
<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				
VISION	Employee: <input type="checkbox"/> I elect coverage	Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No***	Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No***	
<input type="checkbox"/> I decline coverage. I understand if I elect coverage at a later date, late entrant penalties will apply. **				
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 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