

**Guardian Life Insurance Company of America
AFTRA Life Insurance Enrollment Form**

Member Information				
Last Name:		First Name, Middle Initial:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security Number:		Date of Birth:		Effective Date:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Address:		City, State:		Zip Code:
Email:		Home Phone:		Alt. Phone:
How much insurance do you elect for yourself: <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$25,000				
<p>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 Child(ren) <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>AN EVIDENCE OF INSURABILITY FORM(S) MUST BE COMPLETED FOR ANY EMPLOYEE OR DEPENDENT(S) WITH A "YES" ANSWER TO THE ABOVE QUESTION.</p>				
Spouse/ Domestic Partner Information:				
Are you electing coverage for your spouse/ domestic partner: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Last Name:		First Name, Middle Initial:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
				Date of Birth:
				Date of Marriage:
How much insurance do you elect for spouse/ domestic partner: <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$12,500 <input type="checkbox"/> \$0.00				
Child(ren) Information:				
Are you electing coverage for child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No				
Last Name:		First Name, Middle Initial:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
				Date of Birth:
Last Name:		First Name, Middle Initial:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
				Date of Birth:
Last Name:		First Name, Middle Initial:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
				Date of Birth:
Last Name:		First Name, Middle Initial:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
				Date of Birth:
How much insurance do you elect for child(ren): <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$0.00				
Authorization:				
<ul style="list-style-type: none"> • I hereby apply for the group benefit(s) that I have chosen above. • I understand that I must meet eligibility requirements for all coverage's that I have chosen above. • I hereby authorize Babbitt Municipalities, Inc. (d.b.a. Group Benefit Associates) to draft or charge my account for the purpose of collecting premiums for AFTRA Life insurance policy I have accepted to participate in. • The collection of premium will occur on the 15th of the month prior to the start of the next month. • I accept the payment conditions and wish to enroll. • 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 deceptive statement may be guilty of insurance fraud.				
SIGNATURE OF MEMBER:				DATE:

Both sides of form must be filled out completely in order to process the enrollment.

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Designate Beneficiary(s):		
Name (Last, First, Middle)	Relationship	Percentage %

Please Select Payment Method:		
<input type="checkbox"/> Checking Account	Name on account as it appears on check:	
	Bank Name:	
	Routing Number (9 digits):	
	Account Number:	

<input type="checkbox"/> Visa	Name as it appears on card:	
	Credit Card Number:	
	Expiration (MM/YY):	
	Card Security Code (last 3 digits on back of card):	

<input type="checkbox"/> MasterCard	Name as it appears on card:	
	Credit Card Number:	
	Expiration (MM/YY):	
	Card Security Code (last 3 digits on back of card):	

**Mail completed enrollment form to:
Group Benefit Associates
3963 W. Belmont Ave., Suite 6
Chicago, IL 60618**

Or fax to: 773-427-6875

Call with any questions: 800-450-1271

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

**EVIDENCE OF INSURABILITY FOR
NON-MEDICAL COVERAGES**

Please complete in ink. Erasures and changes invalidate this form.

Planholder Name (Company Name)	Group Plan No.
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Complete the following information for each person to be underwritten:

Name (Last, First, Middle Initial)	Sex	Birthdate	Height	Weight	Full Time Student?
Employee:	<input type="checkbox"/> M <input type="checkbox"/> F				
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F				
Child:	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee's Social Security Number		Date of Marriage		Employee's Place of Birth (State)	

**IF APPLYING FOR LIFE INSURANCE: questions 1-4 must be answered for each person to be underwritten
IF APPLYING FOR DISABILITY INSURANCE: all five questions must be answered in reference to the employee only**

1. In the past 10 years been treated for or diagnosed as having: heart; liver or kidney disorder; neurological disorder; diabetes; stroke; cancer; tumor; mental or nervous disorder; or been advised to have treatment for drug abuse (including prescription drugs); or alcoholism?	Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No Child <input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past 5 years used illegal drugs?	Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No Child <input type="checkbox"/> Yes <input type="checkbox"/> No
3. (a) Ever been treated for or diagnosed as having HIV (Human Immunodeficiency Virus)? (b) In the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); lymphadenopathy (enlarged or swollen glands)?	Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No Child <input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past year: (a) consulted or been examined by or treated by a physician, practitioner or specialist? (Include routine physicals only when there is an existing or newly diagnosed medical condition); (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation?; (c) been prescribed medication(s) - (other than for colds, flu or allergies)?	Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No Child <input type="checkbox"/> Yes <input type="checkbox"/> No
5. If applying for disability coverage, please complete these additional questions: (a) In the past 5 years, been treated for conditions of the back, neck, spine, or arthritis?; (b) Are you currently pregnant?; (c) Excluding your employer sponsored group disability plan, are you currently insured for any other disability coverage? If "Yes", what is the total amount of coverage already in-force? \$ _____	Employee <input type="checkbox"/> Yes <input type="checkbox"/> No

For each "Yes" answer to questions 1 through 5b give details below. (*Continue on reverse side if additional space is needed.)

Ques. No.	Name of Patient	Practitioner's Name & Address	Hospital Name & Address	Condition	Duration of symptoms, treatment & degree of recovery	Dates mo/yr

I authorize any physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my eligible dependents to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my eligible dependents. I agree that this authorization will be valid for two and one half years from the date shown below and I have read, understand, and accept the statements and provisions on the reverse side of this application.

Signature of Employee x	Date
Signature of Spouse x	Date

ENDORSEMENT (GUARDIAN USE ONLY)

Employee: <input type="checkbox"/> Approved <input type="checkbox"/> Declined	Premium Class: <input type="checkbox"/> Preferred <input type="checkbox"/> Standard	Child: <input type="checkbox"/> Approved <input type="checkbox"/> Declined	Optional Life: \$ _____	Guardian's Universal Life: \$ _____	Optional Life: \$ _____	Child Term Rider: \$ _____
Spouse: <input type="checkbox"/> Approved <input type="checkbox"/> Declined	Premium Class: <input type="checkbox"/> Preferred <input type="checkbox"/> Standard	Excess Life \$ _____	<input type="checkbox"/> Approved <input type="checkbox"/> Declined	Spouse Term Rider: \$ _____	Long Term Disability \$ _____	<input type="checkbox"/> Approved <input type="checkbox"/> Declined
Optional Life: \$ _____		Short Term Disability \$ _____	<input type="checkbox"/> Approved <input type="checkbox"/> Declined			
Effective Date:	By:	Date:	Secretary			

Read and Detach for your records

Thank you for choosing Guardian insurance. This notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Corporate Secretary, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-2616.

Medical Information Bureau Pre-notice: The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. On the request of any of its member companies to which you apply for life or health insurance, or to which you make a claim for benefits, the Bureau will supply the inquiring company with the information in its files.

Guardian or our reinsurers may make a brief report of objective findings about you to the Bureau. We will not report what action we have taken on your application.

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is Post Office Box 105, Essex Station, Boston, MA 02112, telephone 617-426-3660.

Medical Records: We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

I hereby represent that the statements and answers to the questions on the attached form are, to the best of my knowledge and belief, full, complete and true. I understand that they shall form the basis upon which I may be included for insurance.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (in the case of a late entrant, it is not at the Insurance Company's expense), that I be examined by an accredited medical examiner selected by the Company, (2) no Group Insurance shall be binding or in force until satisfactory evidence of insurability is submitted and approved by the Insurance Company at the Home Office as shown in the Endorsement, and: (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I will become insured on the date I do return to work and satisfy a waiting period (as defined in the Group Plan) of full-time service. (3) coverage for my dependents will not take effect if a dependent other than a newborn is: (a) confined to the hospital or other health care facility; or (b) is unable to perform the normal activities of someone of like age and sex. (4) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (5) the employer is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

Any person who, with intent to defraud or knowing that he 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.

I **authorize** any physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my eligible dependents to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my eligible dependents.

I **understand** The Guardian Life Insurance Company of America will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

I **know** that I may request and receive a copy of this authorization.

I **agree** that a photocopy of this authorization shall be as valid as the original.

I **acknowledge** receipt of Guardian's notice regarding its insurance information practices, and medical records.

I **agree** that this authorization shall be valid for two and one half years from the date signed.