Please print clearly to ensure accurate processing

GUARDIAN®

Employer:
University of Virginia Housestaff Physicians
914 Emmet Street
Charlottesville, VA 22901

Guardian Group Plan Number: **00285129**

❑ **The Guardian Life Insurance Company of America**

❑ **The Guardian Insurance & Annuity Company, Inc.**

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

	Hours Worked	Division	Benefits Effective / /

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

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

YOUR BASIC LIFE COVERAGE

	Policy Amount
Employee	☑ 150% of your annual salary to maximum $100,000

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy $ _____

Name your beneficiaries — Primary beneficiaries must total 100%.

	Relationship to Employee	Percent
Primary Beneficiary 1 First, Middle Initial, Last Name		%
Primary Beneficiary 2		%
Contingent Beneficiary		%

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

Do you, the applicant, have existing life insurance policies or annuity contracts?

❑ Yes ❑ No

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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Nov 28, 2012

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 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 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 acknowledge and agree that Guardian may provide me information concerning benefits, including explanation of benefit statements and other claims related information soley in electronic format as permitted by law. I may change this election only by providing Guardian thirty (30) day prior written notice.
- 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 certify that I, as the Applicant, have read the completed application and understand that any false statement or misrepresentation in this application may result in loss of coverage under this policy.**
- **Any person who, with the 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 have violated state law.**

SIGNATURE OF EMPLOYEE X _____ **DATE** _____