



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

GG-0135C

Enrollment Form

For Non-Medical Coverage

- Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012
- Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040
- Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Planholder Name (Company Name) Synod of the Pacific	Group Plan No. 410059	Division	Class
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Planholder Street Address 200 Kentucky Street, Suite B	City Petaluma	State CA	Zip 94952
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MARITAL STATUS: Single Married Widowed Legally Separated Divorced

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:	<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
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? 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	Annual Salary \$	Occupation /Job Title
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Employee's Street Address	City
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State	Zip	Business Phone #	Home Phone #
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Beneficiary Name (Last, First, Middle), Relationship and % _____ %	Beneficiary Name (Last, First, Middle), Relationship and % _____ %
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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 Yes No **Spouse** Yes No **Child(ren)** Yes No

AN EVIDENCE OF INSURABILITY FORM(S) MUST BE COMPLETED FOR ANY EMPLOYEE OR DEPENDENT(S) WITH A "YES" ANSWER TO THE ABOVE QUESTION.

VOLUNTARY TERM LIFE

Employee:	Spouse: (\$10,000)	Child(ren): (10% of emp amt to \$10,000)
<input type="checkbox"/> \$25,000	<input type="checkbox"/> Yes <input type="checkbox"/> No*	<input type="checkbox"/> Yes <input type="checkbox"/> No*
<input type="checkbox"/> \$50,000		(Less than 14 days is not covered)
<input type="checkbox"/> \$75,000		
<input type="checkbox"/> \$100,000		
<input type="checkbox"/> I decline coverage. * (this also waives dependent coverage).		

DENTAL

Employee:	Spouse:	Child(ren):
<input type="checkbox"/> I elect coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No***	<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		
*** If declining dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		

VISION

Employee:	Spouse:	Child(ren):
<input type="checkbox"/> I elect coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No***	<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 vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*** If declining dependent coverage, are your dependents covered under another vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		

PLEASE READ AND SIGN THE SIGNATURE SECTION ON THE REVERSE SIDE OF THIS FORM

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