



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
- Western Regional Office  
P.O. Box 2454  
Spokane, WA 99210-2454

**GG-013499**  
**Enrollment Form**  
**For Non-Medical Coverages**

|   |                    |   |   |   |
|---|--------------------|---|---|---|
| Planholder Name (Company Name)<br><b>Colville, Inc.</b>   |                    | Group Plan No.<br><b>384485</b>                       | Division  | Class   |
| Planholder Street Address<br><b>702 Barrow Street</b>   |                    | City<br><b>Anchorage</b>                              | State<br><b>AK</b>  | Zip<br><b>99501</b>   |
| <b>MARITAL STATUS:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced   |                    |   |   |   |
| <b>PLEASE CHECK REASON FOR COMPLETING:</b> <input checked="" type="checkbox"/> INITIAL APPLICATION<br><b>CHANGE:</b> <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<br><b>DATE OF CHANGE</b> ___/___/___ <b>REASON FOR CHANGE</b> _____   |                    |   |   |   |
| <b>GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED</b>   |                    |   |   |   |
| 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<br>/ /   |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name and date of placement:<br>(2) Have you included stepchildren? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", indicate name(s):<br>(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<br>\$                                   | Occupation / Job Title  |   |
| Employee's Street Address   |                    | City  |   |   |
| State   | Zip                | Business Phone #                                      | Home Phone #  |   |
| Beneficiary Name (Last, First, Middle), Relationship and %<br>_____ %   |                    |   | Beneficiary Name (Last, First, Middle), Relationship and %<br>_____ % |   |
| <b>BASIC LIFE with Accidental Death &amp; Dismemberment</b>   |                    |   |   |   |
| Employee: <input checked="" type="checkbox"/> Coverage has been paid for you by your company if you meet eligibility requirements.  |                    |   |   |   |
| <b>LONG TERM DISABILITY</b>   |                    |   |   |   |
| Employee: <input checked="" type="checkbox"/> Coverage has been paid for you by your company if you meet eligibility requirements.  |                    |   |   |   |
| <b>DECLINATION OF COVERAGE:</b>   |                    |   |   |   |
| * 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"> <li>• I hereby apply for the group benefit(s) indicated above.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• The information provided above is true and correct to the best of my knowledge.</li> <li>• 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.</li> </ul> |                    |   |   |   |
| X SIGNATURE OF EMPLOYEE   |                    |   |   | DATE  |