



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

Northeast Regional Office
PO Box 26040
Lehigh Valley PA 18002-6040

Bridgewater Office
PO Box 425
E. Bridgewater MA 02333-0425

Western Regional Office
PO Box 2454
Spokane WA 99210-2454

**Enrollment Form
For Non-Medical Coverages**

Planholder Name (Company Name) Thrift Stores	Group Plan No. 347196	Division	Class
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Planholder Street Address	City	State	Zip
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PLEASE CHECK REASON FOR COMPLETING: INITIAL APPLICATION CHANGE: INCREASE ADD DEPENDENT(S)/RIDER(S) PREMIUM CLASS
 DEATH BENEFIT OPTION (GUL ONLY)

GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED

Name (Last, First, Middle Initial)	Sex	Birthdate	Employee Social Security #
Employee:	<input type="checkbox"/> M <input type="checkbox"/> F		

Are you Actively at work Retired
 Marital Status: Single Married Divorced Separated Widowed Dependent Children: Yes No
 Date of Marriage:

Date of Full Time Employment	Hrs. Worked / Week	Annual Salary \$	Occupation /Job Title	Beneficiary(s)	%
Employee's Street Address				Name (Last, First, Middle)	Relationship
Business Phone #				Name (Last, First, Middle)	Relationship

Name (Last, First, Middle Initial)	Sex	Birthdate	Dependent Social Security #
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F		
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F		
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F		
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F		
Child: F/T Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F		

(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):
 Are they dependent on you for support and maintenance? Yes No
 (3) Do any dependents reside at a different address than indicated above? Yes No If "yes" indicate name and address:
 (4) Do any dependent children have a mental or physical handicap or developmental disability? Yes No If "yes" indicate name(s):

OPTIONAL TERM: Issued by: The Guardian Life Insurance Company of America
 Employee Life \$ Spouse Life \$ Child(ren) Life \$ (Birth to 14 days not covered)
 14 days to 6 months \$500
 I decline coverage for Employee Spouse Child(ren). 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.

BASIC LIFE Issued by: The Guardian Life Insurance Company of America
 Employee \$10,00 is provided for you by your company if you meet eligibility requirements.

DENTAL/VISION Issued by: The Guardian Life Insurance Company of America
 Employee Spouse Child(ren)
 I decline coverage for Employee Spouse Child(ren). I understand if I or my dependents elect coverage at a later date, late entrant penalties will apply. If declining coverage, are you or your dependents covered under another dental plan? Yes

- I hereby apply for the group benefit(s) indicated above.
- I understand I must be actively at work or 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 life 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

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN

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