



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

**GG-013500P**  
**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

Bridgewater Office  
P.O. Box 425  
E. Bridgewater, MA  
02333-04251

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

Planholder Name (Company Name) <b>Wetzel County Hospital</b>	Group Plan No. <b>352769</b>	Division	Class
Planholder Street Address <b>3 East Benjamin Drive</b>	City <b>New Martinsville</b>	State <b>WV</b>	Lp <b>26155</b>

**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 checked="" type="radio"/> M <input type="radio"/> F		
Spouse	<input type="radio"/> M <input checked="" type="radio"/> F		Date of Marriage / /
Child	<input type="radio"/> M <input type="radio"/> F		Full Time Student? <input type="radio"/> Yes <input checked="" type="radio"/> No
Child:	<input checked="" type="radio"/> M <input checked="" type="radio"/> F		Full Time Student? <input type="radio"/> Yes <input checked="" type="radio"/> No
Child	<input type="radio"/> M <input type="radio"/> F		Full Time Student? <input type="radio"/> Yes <input checked="" type="radio"/> No
Child	<input type="radio"/> M <input type="radio"/> F		Full Time Student? <input type="radio"/> Yes <input checked="" type="radio"/> 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
Employee's Street Address		City	
State	Zip	Business Phone #	Home Phone #

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?

Spouse  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.**

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

Employee: <input type="checkbox"/> I elect coverage. <input checked="" type="checkbox"/> I decline coverage. I understand if I elect coverage at a later date, late entrant penalties will apply. **	Spouse: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No'	Child(ren): <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No***
** 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: <input type="checkbox"/> I elect coverage. <input checked="" type="checkbox"/> I decline coverage. I understand if I elect coverage at a later date, late entrant penalties will apply. **	Spouse: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No'	Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No'
** 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 SEE SIGNATURE ON BACK OF THIS FORM