GUARDIAN®

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

Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040

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

| Planholder Name (Company Name) | Group Plan No. | Division | Class |
|---|---|---|---|
| Empire State Highway Contractors Association, Inc. | 372939 | | |

| Planholder Street Address | City | State | Zip |
|---|---|---|---|
| 2481 Higby Road | Frankfort | NY | 13340 |

| Company Name | Company Street Address | City | State | Zip |
|---|---|---|---|---|
| | | | | |

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

PLEASE CHECK REASON FOR COMPLETING: ☐ INITIAL APPLICATION

CHANGE: ☐ ADDRESS ☐ NAME ☐ DELETE COVERAGE

DATE OF CHANGE ___/___/___ REASON FOR CHANGE _____

| GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED<br>Name (Last, First, Middle Initial) | Sex | Birthdate | Employee's Social Security # |
|---|---|---|---|
| Employee: | ☐ M ☐ F | | |

| Date of Full Time Employment | Hrs. Worked / Week | 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 % _____ ____%

BASIC LIFE with Accidental Death & Dismemberment

**Employee: ☒ Coverage has been paid for you by your company in the amount of $50,000 if you meet eligibility requirements.**

- 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 and 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 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

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