Please print clearly to ensure accurate processing

Employer:
Archdiocese of Chicago
835 N. Rush Street
Chicago, IL 60611

Guardian Group Plan Number: **387218**

The Guardian Life Insurance Company of America

First Commonwealth Insurance Company

EMPLOYER USE ONLY	New Application Add Dependent(s) Drop Dependent(s) Change Address Change Name Drop Coverage as of: / /		
Class **All Eligible Employees**	Hours Worked	Division	Benefits Effective / /

Keep a copy for your records and return form to: **Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012**

ABOUT YOURSELF

Print clearly in black or blue ink.

First, Middle Initial, Last Name Add Change Drop	Sex M F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -
Address	City	State	Zip
Preferred E-mail	Day Phone	Eve Phone	The best way to reach you: E-mail Day Phone Eve Phone
Job Title	Work Status Full-Time Part-Time Retired COBRA/State Continuation	Date work status began / /	
Are you married? Yes No		Do you have children or other dependents? Yes No	

ABOUT YOUR DEPENDENTS

A sheet with information about additional dependents is attached.

Spouse First, Middle Initial, Last Name Add Change Drop	Sex M F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Marriage Date (mm/dd/yyyy) / /	
Child 1 Add Change Drop	Sex M F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Full-time student, at (school):	Attending Since / /
Child 2 Add Change Drop	Sex M F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Full-time student, at (school):	Attending Since / /
Child 3 Add Change Drop	Sex M F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Full-time student, at (school):	Attending Since / /
Child 4 Add Change Drop	Sex M F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Full-time student, at (school):	Attending Since / /

To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages.
Dental

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Sep 22, 2010

CHOOSE YOUR DENTAL COVERAGE

Check one box only

Your monthly premium	Option 1: Dental DHMO	Option 2: Dental PPO		
Employee alone	$12.96	$36.14		I waive this coverage
Entire family	$30.48	$104.01		I waive this coverage

List dental office location number(s) (Pre-Paid Plan only)

Employee _________________ Spouse/DP _________________ Child(ren) _________________

A separate sheet with additional dental office numbers for dependents is attached.

If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.

Reason for Loss of coverage: Termination of Employment Divorce Death of Spouse Termination or Expiration of coverage

Date of coverage loss / /

If you are waiving coverage, are you covered under another dental plan? Yes No

If you are waiving dependent coverage, are your dependents covered under another dental plan? Yes No

IMPORTANT NOTES

Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

Late entrant penalties or proof of insurability do not apply to Pre-Paid dental coverage. The Pre-Paid dental plan refers to, as applicable, First Commonwealth Insurance Company. Eligibility for this coverage is only available at the open enrollment period.

SIGNATURE

I hereby apply for the group benefit(s) that I have chosen above.
I understand that I must meet eligibility requirements for all coverages that I have chosen above.
I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
I understand that the premium amounts shown above are estimations.
If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
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.

SIGNATURE OF EMPLOYEE X ______________________________ **DATE** ______________