GUARDIAN®

Employer:
Whirlwind Steel Buildings
8234 Hansen Rd.
Houston, TX 77075

Guardian Group Plan Number: **00369716**
Plan Administrator: **Human Resources**

The Guardian Life Insurance Company of America

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EMPLOYER USE ONLY ☐ New Application ☐ Add Dependent(s) ☐ Drop Dependent(s) ☐ Change Address ☐ Change Name ☐ Drop Coverage as of: / /

Class	Hours Worked	Division	Benefits Effective
Class 1 - All Eligible Atlanta			/ /

Keep a copy for your records and return form to: **Western Regional Office, P.O. Box 2454, Spokane, WA 99210-2454**

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 / /	Annual Salary/Earnings $

Are you married? ☐ Yes ☐ No

Do you have children or other dependents? ☐ Yes ☐ No

What is your primary language?

Do you have a disability, which would affect your ability to communicate or read? ☐ 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 / /	

Child 1 ☐ Add ☐ Change ☐ Drop	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy) / /	☐ Full-time student, at (school):	City/State:	Attending Since / /
Child 2 ☐ Add ☐ Change ☐ Drop	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy) / /	☐ Full-time student, at (school):	City/State:	Attending Since / /
Child 3 ☐ Add ☐ Change ☐ Drop	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy) / /	☐ Full-time student, at (school):	City/State:	Attending Since / /
Child 4 ☐ Add ☐ Change ☐ Drop	Sex ☐ M ☐ F	Date of Birth (mm/dd/yyyy) / /	☐ Full-time student, at (school):	City/State:	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.
☐ Long Term Disability ☐ Dental

CHOOSE YOUR LONG-TERM DISABILITY (LTD) COVERAGE

Monthly Benefit

☐ 60% of salary to a maximum of $6,000

☐ I waive this coverage.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Nov 18, 2009

IMPORTANT NOTES

Paying for disability income insurance pre-tax may cause the benefits to be taxable to the recipient at the time of payment.

CHOOSE YOUR DENTAL COVERAGE				*Check one box only*
	DHMO			
Employee alone	☐			☐ I waive this coverage
Employee and Spouse	☐			☐ I waive this coverage
Employee and Child(ren)	☐			☐ I waive this coverage
Entire family	☐			☐ I waive this coverage

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 ☐ Reduction in Work Hours

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 31 days.

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 I must be actively at work or my life and/or disability 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 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.
I attest that 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.

SIGNATURE OF EMPLOYEE X _____ **DATE** _____