



Employer:  
**Averett University**  
**420 West Main Street**  
**Danville, VA 24541**

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

<b>EMPLOYER USE ONLY</b> <input type="checkbox"/> New Application <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Drop Dependent(s) <input type="checkbox"/> Annual Re-enrollment <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name <input type="checkbox"/> Drop Coverage as of: / /			
Class <b>All Other Eligible</b>	Hours Worked	Division	Benefits Effective / /
Keep a copy for your records and return form to: <b>Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012</b>			

<b>ABOUT YOURSELF</b> <span style="float: right;"><i>Print clearly in black or blue ink.</i></span>			
First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> E-mail <input type="checkbox"/> Day Phone <input type="checkbox"/> Eve Phone
Job Title	Work Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation	Date work status began / /	Annual Salary/Earnings \$
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>ABOUT YOUR DEPENDENTS</b> <span style="float: right;"><input type="checkbox"/> A sheet with information about additional dependents is attached.</span>					
Spouse First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Marriage Date (mm/dd/yyyy) / /	
Child 1 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
State of Residence:					
Child 2 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
State of Residence:					
Child 3 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
State of Residence:					
Child 4 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
State of Residence:					

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.  
 Basic Life  Voluntary Life  Long Term Disability

*A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exemption. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.*

**DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER**  
 DATE FORM PUBLISHED: Jul 18, 2011

## YOUR BASIC LIFE COVERAGE

<b>Policy Amount</b>	
Employee	<input checked="" type="checkbox"/> 200% of your annual salary to maximum \$100,000
If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy \$ _____	

Name your beneficiaries			Primary beneficiaries must total 100%.
Primary Beneficiary 1 First, Middle Initial, Last Name	Relationship to Employee	Percent	%
Primary Beneficiary 2			%
Contingent Beneficiary			%
In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.			

## VOLUNTARY LIFE INSURANCE

### CHOOSE YOUR VOLUNTARY TERM LIFE COVERAGE

Employee	Policy Amount	You must be enrolled to cover your dependents.					
<input type="checkbox"/> I waive this coverage	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$60,000	<i>Check one box only</i>
	<input type="checkbox"/> \$70,000	<input type="checkbox"/> \$80,000	<input type="checkbox"/> \$90,000	<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$110,000	<input type="checkbox"/> \$120,000	
	<input type="checkbox"/> \$130,000	<input type="checkbox"/> \$140,000	<input type="checkbox"/> \$150,000*				
*Guarantee Issue Amount							

<b>Add Voluntary Life for Spouse</b>	<i>Check one box only</i>
<input type="checkbox"/> I waive this coverage	<input type="checkbox"/> 50% of employee's amount to maximum \$50,000 \$ _____
<i>The amount may not be more than 50% of the employee amount for Voluntary Life.</i>	
<b>Add Voluntary Life for Child(ren)</b>	<i>Check one box only</i>
<input type="checkbox"/> I waive this coverage	<input type="checkbox"/> 10% of employee's amount to maximum \$10,000 \$ _____
<i>The amount may not be more than 10% of the employee amount for Voluntary Life.</i>	
<input type="checkbox"/> A separate sheet for Voluntary Term Life beneficiaries is attached if they are not the same as those named for Basic Life.	

**Do you, the applicant, have existing life insurance policies or annuity contracts?**

Yes       No

### IMPORTANT NOTES

- If you waive life or disability coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian reserves the right to reject your request.
- Children will not be covered until they reach 14 days.
- Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Voluntary Life and/or Guardian Universal Life.

## LONG TERM DISABILITY

### CHOOSE YOUR LONG-TERM DISABILITY (LTD) COVERAGE

<i>Monthly Benefit</i>
<input checked="" type="checkbox"/> 60% of salary to a maximum of \$5,000

### IMPORTANT NOTES

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

**MEDICAL HISTORY**

Complete the following question if you are enrolling for Voluntary Life and electing an amount above the Guarantee Issue Amount:

In the last 6 months have you or any of your dependents received medical care, including treatment, consultation, services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; any condition related to AIDS or AIDS Related Complex; or any other Chronic Condition?

- Yes, I have
- Yes, my spouse has
- Yes, my child has
- No

An Evidence of Insurability form must be completed for any person with a "Yes" answer to the question above.

**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 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 understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- 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 acknowledge and agree that Guardian may provide me information concerning benefits, including explanation of benefit statements and other claims related information solely in electronic format as permitted by law. I may change this election only by providing Guardian thirty (30) day prior written notice.
- 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 certify that I, as the Applicant, have read the completed application and understand that any false statement or misrepresentation in this application may result in loss of coverage under this policy.**
- **Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.**

**SIGNATURE OF EMPLOYEE X**

**DATE**