GUARDIAN®

Employer:
Rhodes College
2000 N Parkway
Memphis, TN 38112

Guardian Group Plan Number: **00437784**

The Guardian Life Insurance Company of America

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**			

V2.5 E 0001 00437784 key*

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/DP 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.
Dental

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Jan 16, 2009

CHOOSE YOUR DENTAL COVERAGE			*Check one box only*
	Option 1: Split Value Plan	**Option 2: PPO**	
Employee alone			I waive this coverage
Employee and Spouse/DP			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/DP 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/DP, divorce or where a court has ordered coverage be provided for an eligible spouse/DP or eligible children, provided you apply within 30 days.

Vision Discount Access is included with your dental plan at no charge. You must elect dental in order to qualify for Vision Discount Access.

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 attest that the information provided above is true and correct to the best of my knowledge.
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

SIGNATURE OF EMPLOYEE X _____ **DATE** _____