Guardian Life Insurance Company of America
Group Insurance Enrollment Form

Western Regional Office
PO Box 2454
Spokane, WA 99210-2454

Check reason for completing form:

☐ New Subscriber ☐ Delete Coverage ☐ Add a Family Member
☐ Change Address ☐ Change Name ☐ Terminate a Family Member
Date of Change _____ Reason for Change_____

PLANHOLDER NAME (COMPANY NAME)	GROUP PLAN NO.	DIVISION
DATAWORKFORCE, L.P.	**401143**	

PLANHOLDER STREET ADDRESS	CITY	STATE	ZIP
2591 DALLAS PARKWAY, SUITE 300	**FRISCO**	**TX**	**75034**

EMPLOYEE INFORMATION ***(PLEASE PRINT LEGIBLY AS THIS INFORMATION WILL BE DIRECTLY INPUT INTO OUR SYSTEM)***

FIRST NAME	MIDDLE	LAST NAME	SOC. SEC. NO.	BIRTHDATE	SEX

EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP	SALARY

OCCUPATION/JOB TITLE	CLASS	DATE OF FULL-TIME EMPLOYMENT	HOURS WORKED PER WEEK

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

DEPENDENT CHILDREN?
☐ Yes ☐ No

COVERAGE ELECTION

VISION **EMPLOYEE:** ☐ **I elect coverage.** **SPOUSE:** ☐ Yes ☐ No** **CHILD(REN):** ☐ Yes ☐ No**

☐ **I decline coverage** (this also waives **ALL** dependent Vision coverage). I understand if I elect coverage at a later date, late entrant penalties will apply.*

* If declining coverage, are you covered under another Vision plan? ☐ Yes ☐ No
Employer Name _____ Carrier Name _____

** If declining dependent coverage, are your dependents covered under another Vision plan? ☐ Yes ☐ No
Employer Name _____ Carrier Name _____

NAME FIRST, MIDDLE INITIAL, LAST	SOCIAL SECURITY	SEX	RELATIONSHIP	BIRTHDATE	STUDENT
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No

Are any dependent children adopted? ☐ Yes ☐ No If "yes," indicate name and date of adoption: _____
Have you included stepchildren as dependents? ☐ Yes ☐ No If "yes," indicate name(s): _____
Do your stepchildren reside with you? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No

I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make necessary deductions for the contributions, if any, required for insurance, or agree that the contributions be added to my dues; (3) state that I became an employee on the date stated above, and do currently work the number of hours per week stated above; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. Any person who, with 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 be guilty of insurance fraud. I have reviewed the statements on this application and they are true and complete.

SIGNATURE OF EMPLOYEE	DATE