LIFE INSURANCE ENROLLMENT FORM

The Guardian Life Insurance Company of America

Planholder Name (Company Name)	Guardian Group Plan No.: **G-501971**		
HEALTH & WELFARE TRUST FUND OF INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 877 & 70			
Planholder Street Address **89 ACCESS ROAD, UNIT 4**	City **NORWOOD**	State **MA**	Zip **02062**

EMPLOYEE — Please provide this information about YOURSELF

First Name, Middle Initial, Last Name:	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy)	Social Security No.
Address	City	State	Zip
The best way to reach you: _____ Day Phone _____ Evening Phone _____ Email	Day Phone # Email Address	Evening Phone #	
Employer	Job Title	Annual Salary/Earnings $	

LIFE INSURANCE

☐ Benefit as per collective bargaining agreement

☐ I Waive This Coverage

NAME YOUR BENEFICIARIES - Must add up to 100%

Primary Beneficiary 1	Primary Beneficiary 2	Contingent Beneficiary
Name (Last, First, MI)	Name (Last, First, MI)	Name (Last, First, MI)
Relationship to you: ______%	Relationship to you: ______%	Relationship to you: ______%

SIGNATURE

. I hereby apply for the group benefit(s) that I have chosen above.
. I understand that I must meet eligibility requirements for all coverage's 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 agree that my employer may deduct premiums from my pay; 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.
. Any person who with intent to defraud or knowing that he/she is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SIGNATURE OF EMPLOYEE	DATE

FOR FUND USE ONLY		
Class	Division	Benefit Effective