# GUARDIAN LIFE OF THE CARIBBEAN LIMITED
# GROUP HEALTH APPLICATION

**PLAN #** ______________________ **CERT #** ______________________

| Name of Policyholder: | | |
|---|---|---|
| Name of Employee: | | |
| Status: Single or Family | Date of Birth: | Sex: M or F |
| Address: | | |
| Occupation: | | |
| Are you or your spouse covered by any other medical plan? If yes | Name of Plan | Name of Insurance Company |
| **I hereby apply for Registration as a Member of the Group Health Plan of the above Policyholder and authorize deductions to be made by the Policyholder for contributions required to be paid by me in accordance with the terms and conditions of the Plan. I am familiar with the terms and conditions of the Plan and agree to be bound thereby.** | | |
| Employee's Signature: | | Date: |
| Employee's Spouse's Siganture: | | |
| *To be completed by Policyholder* | | |
| Effective Date of Employee's coverage: | Date entered employment/membership: | |

05-02-EB008

## EMPLOYEE'S DEPENDENTS TO BE COVERED

| Name of Dependent | Relationship | Date of Birth | Effective Date of Coverage | Termination Date |
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