GUARDIAN LIFE OF THE CARIBBEAN LIMITED

Looking After Life since 1847

A Member of the Guardian Holdings Group

GUARDIAN LIFE OF THE CARIBBEAN LIMITED
GROUP HEALTH APPLICATION FORM

GROUP POLICY #_____

FORM TO BE COMPLETED IN BLOCK LETTERS

Name of Policyholder/Group:		
Name of Employee:		
Status: Single ☐ Family ☐	Date of Birth (MO-DAY-YR):	Sex: M ☐ F ☐
Address:		
Occupation:		
Are you or your spouse covered by any other medical plan? If yes	Name of Plan/Group:	Name of Insurance Company:
I hereby apply for Registration as a Member of the Group Health Plan of the above Policyholder/Group 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 Signature:		
To be completed by Policyholder/Group:		
Date of Hire:	Date of Confirmation:	
Effective Date of Employee's coverage:		

EMPLOYEE'S DEPENDENTS TO BE COVERED

Name of Dependent/s	Relationship (Spouse/Child)	Gender (M/F)	Date of Birth (MO-DAY-YR)