



Employer:
Acemco Incorporated
7297 Enterprise Drive
Spring Lake, MI 49456

Guardian Group Plan Number: **00455710**

The Guardian Life Insurance Company of America

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EMPLOYER USE ONLY				New Application	Add Dependent(s)	Drop Dependent(s)	Change Address
				Change Name	Drop Coverage as of: / /		
Class	Hours Worked	Division	Benefits Effective				
1			/ /				
Keep a copy for your records and return form to: Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012							

ABOUT YOURSELF						<i>Print clearly in black or blue ink.</i>	
First, Middle Initial, Last Name Add Change Drop				Sex	Date of Birth (mm/dd/yyyy)		Social Security Number
				M F	/ /		- -
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			Date work status began		Annual Salary/Earnings
		Full-Time Part-Time Retired COBRA/State Continuation / /			/ /		\$
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 First, Middle Initial, Last Name Add Change Drop			Sex	Date of Birth (mm/dd/yyyy)	Social Security Number	Marriage Date	
			M F	/ /	- -	/ /	
Child 1	Add	Change	Drop	Sex	Date of Birth (mm/dd/yyyy)	Full-time student, at (school):	City/State: Attending Since
				M F	/ /		/ /
Child 2	Add	Change	Drop	Sex	Date of Birth (mm/dd/yyyy)	Full-time student, at (school):	City/State: Attending Since
				M F	/ /		/ /
Child 3	Add	Change	Drop	Sex	Date of Birth (mm/dd/yyyy)	Full-time student, at (school):	City/State: Attending Since
				M F	/ /		/ /
Child 4	Add	Change	Drop	Sex	Date of Birth (mm/dd/yyyy)	Full-time student, at (school):	City/State: Attending Since
				M F	/ /		/ /
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.							
Basic Life Voluntary Life Dental							

YOUR BASIC LIFE COVERAGE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)	
Policy Amount	
Employee	<input checked="" type="checkbox"/> \$20,000
If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy \$ _____	

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
 DATE FORM PUBLISHED: Jan 22, 2010

LIFE INSURANCE *continued*

Name your beneficiaries		Primary beneficiaries must total 100%.	
Primary Beneficiary 1 First, Middle Initial, Last Name	Relationship to Employee	Percent	
			%
Primary Beneficiary 2			%
Contingent Beneficiary			%

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

CHOOSE YOUR VOLUNTARY TERM LIFE COVERAGE				<i>Check one box only</i>
Employee	Policy Amount			You must be enrolled to cover your dependents.
	\$25,000	\$50,000	\$75,000	
<i>*Guarantee Issue Amount</i>				
I waive this coverage				
Add Voluntary Life for Spouse	<i>Check one box only</i>			
	50% of employee's amount to maximum \$50,000			
I waive this coverage <i>The amount may not be more than 50% of the employee amount for Voluntary Life.</i>				
Add Voluntary Life for Child(ren)	<i>Check one box only</i>			
	10% of employee's amount to maximum \$10,000			
I waive this coverage <i>The amount may not be more than 10% of the employee amount for Voluntary Life.</i>				
A separate sheet for Voluntary Term Life beneficiaries is attached if they are not the same as those named for Basic Life.				

For Voluntary Life, an Evidence of Insurability form must be completed for any amount above the Guarantee Issue.

IMPORTANT NOTES

If you waive life or disability coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian reserves the right to reject your request. Children will not be covered until they reach 14 days.

Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Voluntary Life and/or Guardian Universal Life.

CHOOSE YOUR DENTAL COVERAGE				<i>Check one box only</i>
	100/50/50			
Employee alone				I waive this coverage
Employee and 1 Dependent				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			Date of coverage loss	
Termination or Expiration of coverage			/ /	
If you are waiving coverage, are you covered under another dental plan?		If you are waiving dependent coverage, are your dependents covered under another dental plan?		
Yes No		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, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

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 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 understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.

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 understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
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 an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SIGNATURE OF EMPLOYEE **X**

DATE
