GUARDIAN®

Employer:
Wente Vineyards
5565 Tesla Road
Livermore, CA 94550

Guardian Group Plan Number: **00374462**

The Guardian Life Insurance Company of America

EMPLOYER USE ONLY ❑ New Application ❑ Add Dependent(s) ❑ Drop Dependent(s) ❑ Change Address ❑ Change Name ❑ Drop Coverage as of: / /

	Hours Worked	Division	Benefits Effective / /

Keep a copy for your records and return form to: **Western Regional Office, P.O. Box 2454, Spokane, WA 99210-2454**

ABOUT YOURSELF

Print clearly in black or blue ink.

First, Middle Initial, Last Name ❑ Add ❑ Change ❑ Drop	Sex ❑M ❑F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -

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 ❑ Full-Time ❑ Part-Time ❑ Retired ❑ COBRA/State Continuation	Date work status began / /

Are you married? ❑ Yes ❑ No If you have a domestic partner (DP), is your partnership registered with the State of California? ❑ Yes ❑ No

Do you have children or other dependents? ❑ Yes ❑ No

ABOUT YOUR DEPENDENTS

❑ A sheet with information about additional dependents is attached.

Spouse/DP First, Middle Initial, Last Name ❑ Add ❑ Change ❑ Drop	Sex ❑M ❑F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Marriage Date / /	

Child 1 ❑ Add ❑ Change ❑ Drop	Sex ❑M ❑F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 2 ❑ Add ❑ Change ❑ Drop	Sex ❑M ❑F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 3 ❑ Add ❑ Change ❑ Drop	Sex ❑M ❑F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 4 ❑ Add ❑ Change ❑ Drop	Sex ❑M ❑F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /

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.
❑ Dental

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

CHOOSE YOUR DENTAL COVERAGE	PPO			Check one box only
Employee alone	❑			❑ I waive this coverage
Employee and Spouse/DP	❑			❑ I waive this coverage
Employee and Child(ren)	❑			❑ 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/DP ❑ Termination or Expiration of coverage

Date of coverage loss / /

If you are waiving coverage, are you covered under another dental plan? ❑ Yes ❑ No

If you are waiving dependent coverage, are your dependents covered under another dental plan? ❑ 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/DP, divorce or where a court has ordered coverage be provided for an eligible spouse/DP or eligible children, provided you apply within 30 days.
- Vision Discount Access is included with your dental plan at no charge. You must elect dental in order to qualify for Vision Discount Access.

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 my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- 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 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** _____