



Employer:
DEM Group, LLC
44056 Mound Road
Suite 105
Sterling Heights, MI 48314

Guardian Group Plan Number: **00449478**

The Guardian Life Insurance Company of America

First Commonwealth Limited Health Services Corporation of Michigan

EMPLOYER USE ONLY <input type="checkbox"/> New Application <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Drop Dependent(s) <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name <input type="checkbox"/> Drop Coverage as of: / /			
Class All Eligible Employees	Hours Worked	Division	Benefits Effective / /
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 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> E-mail <input type="checkbox"/> Day Phone <input type="checkbox"/> Eve Phone
Job Title	Work Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation	Date work status began / /	Annual Salary/Earnings \$
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	

ABOUT YOUR DEPENDENTS <input type="checkbox"/> A sheet with information about additional dependents is attached.				
Spouse First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Marriage Date (mm/dd/yyyy) / /
Child 1 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	<input type="checkbox"/> Full-time student, at (school): Attending Since / /
Child 2 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	<input type="checkbox"/> Full-time student, at (school): Attending Since / /
Child 3 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	<input type="checkbox"/> Full-time student, at (school): Attending Since / /
Child 4 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	<input type="checkbox"/> Full-time student, at (school): 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. <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Dental <input type="checkbox"/> Vision				

CHOOSE YOUR VOLUNTARY TERM LIFE COVERAGE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) <i>Check one box only</i>					
Employee	Policy Amount	You must be enrolled to cover your dependents.			
	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$200,000				
<input type="checkbox"/> I waive this coverage					

LIFE INSURANCE *continued*

Add Voluntary Life for Spouse	<i>Check one box only</i>
<input type="checkbox"/> I waive this coverage	<input type="checkbox"/> 50% of employee's amount to maximum \$50,000 The amount may not be more than 50% of the employee amount for Voluntary Life.

Add Voluntary Life for Child(ren)	<i>Check one box only</i>
<input type="checkbox"/> I waive this coverage	<input type="checkbox"/> 10% of employee's amount to maximum \$10,000 The amount may not be more than 10% of the employee amount for Voluntary Life.

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.

For Voluntary Life, you must answer the following question.

- In the last 6 months, have you or any of your dependents received medical care, including treatment, consultation, services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer; Heart Disease; Diabetes; any condition related to AIDS or AIDS Related Complex; or any other Chronic Condition?

Employee: Yes No Spouse: Yes No Child(ren): Yes No

For Voluntary Life, an Evidence of Insurability form must be completed for any person with a "yes" answer to any of the above questions or for any amount elected above the Conditional Issue amount.

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>
Employee alone	Option 1: Dental HMO <input type="checkbox"/>	Option 2: Dental PPO <input type="checkbox"/>	<input type="checkbox"/> I waive this coverage
Employee and 1 Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I waive this coverage
Entire family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I waive this coverage

List dental office location number(s) (Network Plan only)

Employee _____ Spouse/DP _____ Child(ren) _____

A separate sheet with additional dental office numbers for dependents is attached.

If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.

Reason for Loss of coverage: <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Spouse <input type="checkbox"/> Termination or Expiration of coverage	Date of coverage loss / /
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If you are waiving coverage, are you covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you are waiving dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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.
- Late entrant penalties or proof of insurability do not apply to Network dental coverage. The Pre-Paid dental plan refers to First Commonwealth Limited Health Services Corporation of Michigan. Eligibility for this coverage is only available at the open enrollment period.

CHOOSE YOUR VISION COVERAGE			Check one box only
	Option 1: High Option	Option 2: Low Option	
Employee alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I waive this coverage
Employee + 1 Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I waive this coverage
Entire family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I waive this coverage
If you are waiving coverage, are you covered under another vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you are waiving dependent coverage, are your dependents covered under another vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

IMPORTANT NOTES

- If I have waived the vision coverage, and elect coverage at a later date, enrollment delays may apply.
- Your plan includes a One Year Lock-In/Lock-Out Provision - Your election to enroll in or waive vision coverage must remain in effect until your plan's next annual vision enrollment period.

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