Guardian Life Insurance Company of America
Group Insurance Enrollment Form

Northeast Regional Office
'O Box 26050
:high Valley, PA. 18002

Check reason for completing form:
☐ New Subscriber ☐ Delete Coverage ☐ Add a Family Member
☐ Change Address ☐ Change Name ☐ Terminate a Family Member
Date of Change ____________ Reason for Change

PLANHOLDER NAME (COMPANY NAME)		GROUP PLAN NO.	RIG NAME
SCANDRILL, INC.		358556	
PLANHOLDER STREET ADDRESS	CITY	STATE	ZIP
11777 KATY FREEWAY SUITE # 470	HOUSTON	TX	77079

EMPLOYEE INFORMATION ***(PLEASE PRINT LEGIBLY AS THIS INFORMATION WILL BE DIRECTLY INPUT INTO OUR SYSTEM)***

FIRST NAME	MIDDLE	LAST NAME	SOC. SEC. NO.	BIRTHDATE	SEX

EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP

OCCUPATION/JOB TITLE	DATE OF FULL-TIME EMPLOYMENT	HOURS WORKED PER WEEK
		85

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced
DEPENDENT CHILDREN? ☐ Yes ☐ No

COVERAGE ELECTION

BASIC LIFE & AD&D EMPLOYEE: ☒ This is a Company paid coverage which you will receive if eligible

MEDICAL/VISION PLAN EMPLOYEE: ☐ I elect coverage. SPOUSE: ☐ Yes ☐ No** CHILD(REN): ☐ Yes ☐ No**

☐ **I decline coverage** (this also waives **ALL** dependent Medical coverage). I understand if I elect coverage at a later date, late entrant penalties will apply.*
* If declining coverage, are you covered under another Medical plan? ☐ Yes ☐ No
** If declining dependent coverage, are your dependents covered under another Medical plan? ☐ Yes ☐ No

Employer Name ____________________ Carrier Name ____________________

DENTAL EMPLOYEE: ☐ I elect coverage. SPOUSE: ☐ Yes ☐ No** CHILD(REN): ☐ Yes ☐ No**

Value Plan (A) _____ **Network Access Plan (B)** _____

☐ **I decline coverage** (this also waives **ALL** dependent Dental coverage). I understand if I elect coverage at a later date, late entrant penalties will apply.*
* If declining coverage, are you covered under another Dental plan? ☐ Yes ☐ No
** If declining dependent coverage, are your dependents covered under another Dental plan? ☐ Yes ☐ No

Employer Name ____________________ Carrier Name ____________________

Please list dependents you want covered on the plan

NAME FIRST, MIDDLE INITIAL, LAST	SOCIAL SECURITY	SEX	RELATIONSHIP	BIRTHDATE	STUDENT
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No
		☐ F ☐ M			☐ Yes ☐ No

Are any dependent children adopted? ☐ Yes ☐ No If "yes," indicate name and date of adoption: ____________
Have you included stepchildren as dependents? ☐ Yes ☐ No If "yes," indicate name(s): ____________
Do your stepchildren reside with you? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No

EMPLOYEE BENEFICIARY DESIGNATION (Include full proper name and relationship; i.e.: Mary A. Jones, wife.)

NAME	RELATIONSHIP

I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make necessary deductions for the contributions, if any, required for insurance, or agree that the contributions be added to my dues; (3) state that I became an employee on the date stated above, and do currently work the number of hours per week stated above; and (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. Any person who, with intent to defraud or knowing that he 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. I have reviewed the statements on this application and they are true and complete.

'GNATURE OF EMPLOYEE	DATE

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO THE GUARDIAN