Please print clearly to ensure accurate processing

GUARDIAN®

Employer:
Cypress-Fairbanks I.S.D.
10300 Jones Road
Houston, TX 77065

Guardian Group Plan Number: **00460832**

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: / /

Class	Hours Worked	Division	Benefits Effective
All Eligible Employees			/ /

Keep a copy for your records and return form to: **Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012**

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

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

What is your primary language?

Do you have a disability, which would affect your ability to communicate or read? ❑ Yes ❑ No

ABOUT YOUR DEPENDENTS

❑ A sheet with information about additional dependents is attached.

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Oct 13, 2011

CHOOSE YOUR VISION COVERAGE

Check one box only

Your monthly premium	Full Feature			
Employee alone	❑ **$9.88**			❑ I waive this coverage
Employee and Spouse	❑ **$16.62**			❑ I waive this coverage
Employee and Child(ren)	❑ **$16.96**			❑ I waive this coverage
Entire family	❑ **$26.84**			❑ I waive this coverage

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

If you are waiving dependent coverage, are your dependents covered under another vision plan? ❑ Yes ❑ 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 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 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** _____