PACIFIC GUARDIAN LIFE

1440 Kapiolani Boulevard, Suite 1700
Honolulu, Hawaii 96814

RESET

Group Insurance
Enrollment Application

THIS SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer	Group Policy Number	LTD Policy Number	Emp Class

THIS SECTION TO BE COMPLETED BY EMPLOYEE - PLEASE PRINT **FOR PGL USE ONLY**

Your Last Name	First Name	Middle Initial(s)	Issue Age
Address			Effective Date
Sex ☐ M ☐ F	Birthdate (month/day/year)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Term Amount
Social Security Number	Date Employed (month/day/year)	Date Full-Time (month/day/year)	AD&D Amount
Beneficiary's First Name	Middle Initial(s) / Last Name	Relationship	Dependent
			A
Job Title	Earning Basis ☐ Salary ☐ Hourly	Earnings $ _____ Per: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually	LTD
How many hours do you work per week?	Dependent Insurance? ☐ Yes ☐ No	Do you wish to participate in Supplemental Insurance? ☐ Yes ☐ No	

I desire participation in the group insurance program and authorize my employer to deduct any required cost from my earnings.

Signature: x _____ Date _____

Complete Section Below for Waiver of Coverage

PLEASE PRINT CLEARLY

Employer/Company		Policy Number
Employee's Last Name	First Name	Middle Initial

I have been given an opportunity to apply for Group Insurance provided by my employer through Pacific Guardian Life Insurance Company, Ltd.

After serious consideration, I have elected not to take advantage of this offer.

This refusal is applicable to (check all that apply):

- ☐ All insurance coverage for which I am eligible.
- ☐ Supplemental Insurance.
- ☐ Dependent Insurance.
- ☐ Other: _____

I understand that I may be required by Pacific Guardian Life to provide evidence of insurability should I desire to apply at a later date.

Employee's Signature x _____ Date Signed _____