GUARDIAN LIFE LIMITED

GUARDIAN HEALTH SUPPLEMENTAL INSURANCE EB 306

PLEASE USE BLOCK LETTERS WHEN COMPLETING THIS FORM.

NAME OF EMPLOYER/POLICYHOLDER: _____

NAME OF EMPLOYEE: ☐ **Mr.** ☐ **Mrs.** ☐ **Miss** _____

First **Middle** **Last**

EMPLOYEE DATE OF BIRTH: _____ _____ _____ **SEX:** ☐ Female ☐ Male

DD **MM** **YYYY**

CARDHOLDER NUMBER: _____

EMPLOYEE TRN: _____

The supplemental plan is designed to provide additional coverage to your base plan. Coverage will be extended in accordance with your base plan i.e. employee only, employee with one dependent or employee with family.

In accordance with the options provided under my Employer's Group Health Insurance Policy, underwritten by Guardian Life Limited, I elect coverage as indicated above and hereby authorize my employer to deduct the amount of _____Dollars ($ _____) from my salary, commencing _____. This amount is to be submitted to Guardian Life Limited on a monthly basis to cover premiums, in respect of Supplemental Health Insurance. This authority shall remain in effect until cancelled by me, or replaced with another authorization.

Day **Month** **Year**

Signature of Employee: _____ **Date:** _____

COMPANY STAMP:

_____

Authorised Signature on behalf of Employer