☐ Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040

☐ Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012

☐ Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

SPECIFICATIONS FOR A NON MEDICAL PLAN OF GROUP INSURANCE

Please Print GROUP PLAN NUMBER (Guardian Use Only)

☐ New Plan ☐ Change of Plan Requested effective date:

SECTION I PLANHOLDER INFORMATION

Planholder Name (full legal name of company) | Tax I.D. #

Main Address (street, city, state, zip)

Mailing Address (street, city, state, zip)

Name of Correspondent Title: | Phone No: ( ) | Fax No: ( )

Type of organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain)

Include eligible employees who work: ☐ 30 Hrs/Wk ☐ Other

No. of full-time employees: No. of full-time employees to be insured: Total number of employees:

Are all full-time employees to be included? ☐ Yes ☐ No Indicate class or classes to be excluded:

Premium Paid: ☐ Monthly ☐ Quarterly ☐ Annual ☐ Semi Annual
For plans with less than 10 employees: ☐ GOM ☐ Annual | Deposit $

Nature of business (specify) | Date Est. | SIC.

Affiliates, subsidiaries or branches (legal name & location)	Nature of business/ Type of Organization	No. of f/t emp's in this company	No. of f/t emp's to be insured

SECTION II SUPPLEMENTARY INFORMATION *(All questions must be answered)*

1. Has this firm or any of its affiliates, either under its present name or under any other name, ever applied for group insurance with Guardian or The Guardian Insurance and Annuity Company, Inc.? ☐ Yes ☐ No If "yes", furnish name of employer, plan number and date of cancellation:

2. Name of present or prior group carrier: Cancellation Date:
What coverages are now or were in force? ☐ Life ☐ Medical ☐ Dental ☐ Prescription Drug ☐ Vision ☐ Short Term Disability ☐ Long Term Disability *(Please attach copies of booklet and current billing statement)*

3. ***For plans requesting life insurance:*** Is the disability waiver of premium benefit to be included?	☐ Yes ☐ No
Will this insurance replace any existing life insurance or annuity?	☐ Yes ☐ No
4. If present carrier provided life insurance, are extended benefits provided in case of disability?	☐ Yes ☐ No
5. To the best of your knowledge are any employees or dependents currently disabled? If "yes", please indicate: ☐ actively at work ☐ on disability leave/claim ☐ other (please provide details on back of form)	☐ Yes ☐ No
6. ***For plans with less than 100 eligible employees***: To the best of your knowledge has any employee or dependent *within the past three years*, been treated for or diagnosed as having: cancer; heart disease; kidney disorder; stroke or other serious disease?	☐ Yes ☐ No
7. ***For plans with less than 100 eligible employees***: To the best of your knowledge has any employee or dependent, been diagnosed as having AIDS or AIDS Related Complex?	☐ Yes ☐ No
8. ***For plans with less than 500 eligible employees:*** To the best of your knowledge has any employee or dependent, *within the past two years,* suffered a condition which resulted in a health insurance claim of $25,000 or greater ($50,000 or greater for plans with more than 100 eligible employees)?	☐ Yes ☐ No

If any questions in Section II of this form were answered "yes", please provide an explanation using the additional space below. Refer to the specific question number, and give details including names where appropriate. If additional space is needed, use a separate sheet of paper, and refer to the question number. Be sure to sign, date and have it witnessed.

Question No.	Explanation

SECTION III	COVERAGE ELECTION

Insurance to be issued: "N" for non contributory or "C" for contributory. If "C" indicate % of employee contribution.

Employee:	Life %	Dental %	Vision %	STD %	LTD %
Dependent:	Life %	Dental %	Vision %		

SECTION IV	AGENT INFORMATION/SIGNATURE

 # 1) Agent Name: ______________________________ % _______ Code: __________ Guardian Agency: ____________ Code: ___________

Agent Address: ____
Street City State Zip Code

For life insurance only: To the best of your knowledge, will this insurance replace any existing life insurance or annuity? ☐ Yes ☐ No

Agent Signature: ____________________________________ Soc. Sec. # __________________________ Tax ID # __________________

 # 2) Agent Name: ______________________________ % _______ Code: __________ Guardian Agency: ____________ Code: ___________

Agent Address: ____
Street City State Zip Code

For life insurance only: To the best of your knowledge, will this insurance replace any existing life insurance or annuity? ☐ Yes ☐ No

Agent Signature: ____________________________________ Soc. Sec. # __________________________ Tax ID # _________________

Sales Office _______________________________ Sales Representative _____________________________________ Code _____________

SECTION V	AGREEMENT

Request for Participation In A Certain Trust Agreement

The undersigned Planholder engaged primarily in the industry described in Section I, hereby requests that it be approved as a participant in the Trust established by other Planholders engaged in the same industry for the purpose of purchasing insurance for the benefit of their employees and requests inclusion as a participant under the Group Insurance Plan(s) issued to the Trustee for the plan(s) of insurance shown in Section III.

Conditions of Agreement

It is understood that no individual shall become insured while not actively at work on a full-time basis, and only full-time employees shall be eligible. Full-time employee means one who regularly works at least the number of hours in the normal work week established by this Planholder *(but not less than 30 hours per week*) at his Planholder's place of business. It is further understood that no agent has power on behalf of The Guardian Life Insurance Co. of America to make or modify any request or application for insurance, or to bind said Insurance Company by making any promise or representation or by giving or receiving any information. It is further understood that no insurance will be effective until the plan is accepted in writing by the Insurance Company. No contract of insurance is to be implied in any way on the basis of the completion and submission of the specifications shown on both sides of this form.

It is further understood that no insurance will be effective until the plan is accepted in writing by the Insurance Company. No contract of insurance is to be implied in any way on the basis of the completion and submission of the specifications shown on both sides of this form.

"Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree".

I have reviewed the statements made by me on this application, and they are true and complete.

Signature and Title of Officer,
Partner or Proprietor: ____ Date: ______________________

Print Name of Officer, Partner
or Proprietor: ____

Signature of Witness: ____ Date: ______________________

City and State Where Signed: ____