

Please Print

Plan number (Guardian use only):

New Plan       Change in plan      Requested effective date:

**SECTION I: PLANHOLDER INFORMATION:** No. employees of your company: \_\_\_\_\_ No. of eligible employees to be insured: \_\_\_\_\_

Planholder (full legal name of company): \_\_\_\_\_ TAX IDENTIFICATION NO. \_\_\_\_\_

Main address: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing address: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of correspondent: \_\_\_\_\_ Title: \_\_\_\_\_ Phone No.: (    ) \_\_\_\_\_

Type of organization:  Corporation     Partnership     Proprietorship     Other (explain)

Nature of business (specify): \_\_\_\_\_ SIC: \_\_\_\_\_

Deposit \$ \_\_\_\_\_ GOM required unless paid annually.

Affiliates, subsidiaries or branches: Legal Name & Location	No. employees of this company	No. of employees to be insured	Nature of business

**SECTION II: SPECIFICATIONS FOR A PLAN OF GROUP INSURANCE**

Include eligible employees who work (check one):     At least 30 hours/week     At least 17.5 hours/week

Class or classes to be excluded:

Waiting period before employee becomes insured? Presently employed: None    Future: (15<sup>th</sup> of the month following date of approval.)

Insurance to be issued, indicate "N" if non-contributory or "C" if contributory, by each coverage below:

Employee:	Life	Major Medical	Dental	Short Term Disability*	Long Term Disability*
Dependent:	Life	Major Medical	Dental	*If "C" employees contribution	%

**LIFE INSURANCE**

**Plan of Insurance** (An employee is eligible only for the amount shown for his/her classification):

Classification	Basic Life	AD&D	Supp	STD	LTD

**Reduction:**  50% at age:     Other:    **Redetermined** (if based on earnings): 15<sup>th</sup> of the month following date of approval.

**Dependent Life:** Spouse \$ \_\_\_\_\_ Child, 14 days to 6 mo. \$ \_\_\_\_\_ Child, 6 mo. to age \$ \_\_\_\_\_

**MAJOR MEDICAL BENEFITS\*      Deductible \$**

**Plan Type:**  BC-BS     BC (WRAP)     Other     Comprehensive    **Accumulation Period:**  Calendar Year     Policy Year     Per Cause    Days

**Basic Benefits** (describe): \_\_\_\_\_ **Conversion:**  Statutory     Limited     Regular

**Deductible:** Waived for  Accident     Surgery & Anesthesia     Not waived     Cost containment

**Limits:** Room and Board     S/P     Dynamic R&B Less \$ \_\_\_\_\_ for \_\_\_\_\_ days    **Maximum: \$**     Unlimited     1,000,000.

**Co-insurance:** \_\_\_\_\_ % to Maximum \$    **Mental & Nervous Benefits:** In Hosp. \_\_\_\_\_ Out of Hosp. \_\_\_\_\_

**Limitation on Pre-existing Conditions:**  Included     Included but "No Loss-No Gain" concept applied

\* Includes

Maternity as any other illness

Prescription Card Service

\$100 Major Medical Deductible - \$3.00 PCS deductible

\$300 - \$500 Major Medical Deductible - \$5.00 PCS deductible

\$200 Major Medical Deductible - \$4.00 PCS deductible

Major Medical Deductible over \$500 - PCS not included

**DENTAL BENEFITS      Deductible: \$      Maximum: \$      Plan Type:** Deferred Major/Periodontic

**Co-insurance:** Preventive 100%    Basic 80%    Major 50%    Periodontic 80%    **Deductible:** Waived for  Preventive     Not waived

**Remarks:**

EMPLOYEE DISABILITY BENEFITS		Short Term: <input type="checkbox"/> Basic <input type="checkbox"/> Intermediate		Long Term <input type="checkbox"/>	
Class	% of Salary	to \$	Class	% of Salary	to \$
<b>Elimination Period:</b> Accident		Sickness	<b>Elimination Period:</b> Accident		Sickness
<b>Benefit Duration:</b> Accident		Sickness	<b>Benefit Duration:</b> Accident		Sickness
<b>Tax Identification #:</b>					
<b>If Plan Includes Long Term Disability Complete the Following:</b>			<b>Length of time in business (years):</b>		
<b>Benefit Reduction:</b> <input type="checkbox"/> Direct Primary <input type="checkbox"/> All Sources 70% (Full)			<b>Redetermination:</b> 15 <sup>th</sup> of the month following date of approval.		
<b>Pre-existing Conditions:</b> *3/12 **"No Loss-No Gain" on transferred cases					
Remarks:					

**SECTION III: 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 The Guardian Life Insurance Company of America?  Yes  No If "yes", please furnish year, name of employer, plan number.
2. Are any eligible employees related to the planholder (principal[s])?  Yes  No If "yes", list full names.
3. Is there any insurance plan: A) Now in force and to be continued?  Yes  No B) Currently being applied for?  Yes  No If "yes", give description of plan and name of insurance carrier(s).
4. Name of present or prior carrier: \_\_\_\_\_ 4a. Cancellation date: \_\_\_\_\_
5. What forms of insurance are now or were in force?  Life  Major Medical  Short Term Disability  Long Term Disability  Dental  Prescription Drugs Attach copies of Booklet and Billing Statement.
6. If present carriers provided health insurance are extended benefits provided in case of termination of the master plan?  Yes  No
7. To the best of your knowledge: A) If present or prior carrier(s) provided health insurance, did any employee or dependent suffer a condition which resulted in a claim of \$5,000 or more during the last 2 years?  Yes  No  
 B) Has any employee or dependent had heart disease, cancer, kidney disorder, stroke, AIDS, AIDS Related Complex or other serious disease?  Yes  No  
 C) Are any dependent children incapable of self-support because of a physical or mental disability?  Yes  No  
 D) Are any employees or dependents presently incapacitated?  Yes  No
8. To the best of your knowledge: Are there any current or former employees or eligible dependents whose health insurance is being continued?  Yes  No Please provide the following information for each current/former employee or dependent on health continuation.

Employee/ Dependent	D/O/B	TYPE of CONTINUATION State/Federal/Extended Benefits	REASON for TERMINATION Disability/Non-Disability	CONTINUATION DATES Start Date/Expiration Date

Additional space to explain if questions 1-8 were answered "yes". Refer to the appropriate question number and give details, including names where appropriate.

**SECTION IV: Agent** A) Name: \_\_\_\_\_ Code: \_\_\_\_\_ B) Guardian agency: \_\_\_\_\_ Code: \_\_\_\_\_

**Request For Participation In A Certain Trust Agreement To: Rhode Island Hospital Trust National Bank (Trustee)**

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 I.

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.

Authorized Signature and Title \_\_\_\_\_ Date \_\_\_\_\_

Witness to Signature \_\_\_\_\_



**SUPPLEMENTAL APPLICATION**

**ATTACHED TO AND MADE PART OF THE APPLICATION**

**“Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.”**