

Please Print PLAN NUMBER (Guardian and Health Net Use only):

New Plan Change of Plan Requested effective date:

SECTION I: PLANHOLDER INFORMATION

Planholder (full legal name of company): Tax ID #:

Main Address (street, city, state, zip):

Mailing Address (street, city, state, zip):

Email Address: Fax No.: () Phone No.: ()

Name of correspondent: Title:

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

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

Deposit \$ Nature of Business (specify): Date established: SIC:

Waiting period before employee becomes insured? Present: Future:

Do you have any affiliates, subsidiaries or branches? Yes No

Affiliates, subsidiaries or branches (legal name & location)	Nature of business	No. of full-time emps. this co.	No. of full-time emps. To be ins.

SECTION II: SPECIFICATION FOR A PLAN OF GROUP INSURANCE

Are all full-time employees (working at least 30 hours per week) to be included? Yes No If "no," indicate class or classes to be excluded?

Percentage of employer contribution for medical coverage: Employee Coverage: % Dependent Coverage: %

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 Guardian and/or The Guardian Insurance and Annuity Company? Yes No If "yes," furnish year, name of employer, plan number and date of cancellation:

2) If present carrier provided life insurance, are extended benefits provided in case of disability? Yes No

3) Does your firm have any other insurance plan:
 a) Now in force and to be continued? Yes No
 b) That you are currently applying for? Yes No
 If "yes," give description of plan and name of carrier(s):

4) Name of present or prior group carrier: Cancellation Date:

5) What coverages are now or were in force?
 Life Optional Life Medical Dental Prescription Drugs STD LTD Vision
(Please attach copies of booklet and current billing statement)

6) To the best of your knowledge, are there any current and former employees or their eligible dependents whose health insurance is being continued? Yes No Please provide the following information on health continuation for each current/former employee or dependent:

Employee/Dependent	D/O/B	Continuation State / Federal	Continuation due to Disability / Non-Disability	Continuation Dates Start / Expiration

SECTION IV: EXPERIENCE INFORMATION (If additional space is needed, please complete on a separate sheet and attach)

To the best of your knowledge:

1) a. Are any employees or dependents presently incapacitated? Yes No
 b. Are any dependent children incapable of self-support because of a physical or mental disability? Yes No

2) Has any employee or dependent active or on continuation, ever been treated for or diagnosed as having cancer, heart disease, kidney disorder, stroke, AIDS, AIDS Related Complex or other serious disease? Yes No

3) If present or prior carrier provided health insurance, did any insured, active or on continuation suffer a condition which resulted in a claim \$10,000 or more in the past 2 years? Yes No

4) Has any employee been absent from work for 10 or more consecutive days due to illness or injury in the last 12 months? Yes No

If any questions in Section IV were answered "yes," please explain, using the additional space designated "Detailed Explanations" on the reverse side of this application. Refer to the specific question number, and give details (including names where appropriate).

Be certain to read this entire application: then sign, date, and have it witnessed on the reverse side.

DETAILED EXPLANATIONS (Section IV, questions 1-3 include all appropriate information)

Question No.	Explanatory Information

If additional space is needed, use a separate sheet of paper, and refer to question number. Be sure to sign, date and have witnessed.

SECTION V: BROKER INFORMATION

Broker Name: _____ Code: _____ Guardian Agency: _____ Code: _____

Broker Address: _____
 Street City State Zip Code

Broker Signature: _____ Tax ID # _____

Broker Name: _____ Code: _____ Guardian Agency: _____ Code: _____

Broker Address: _____
 Street City State Zip Code

Broker Signature: _____ Tax ID # _____

Sales Office: _____ Sales Representative: _____

CERTIFICATION:

COMPLETE IF YOU DO MEET THE DEFINITION OF A SMALL EMPLOYER:
 I certify that I qualify as a Small Group Employer in that on at least fifty percent of the working days in the preceding year there were no more than fifty full-time employees, including full-time employees employed by an affiliated company, the majority of whom were employed in the State of Connecticut.

I have reviewed the statements made by me on the supplement, and to the best of my knowledge and belief, they are true and complete.

Initial of Officer, Partner or Proprietor: _____

-----**WE MUST HAVE A COPY OF YOUR MOST RECENT STATE/FEDERAL QUARTERLY WAGE REPORT**-----

Request For Participation In A Certain Trust Agreement:
 The undersigned employer, engaged primarily in the industry described in Section 1, hereby requests that it be approved as a participant in the Trust established by other employers 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.

It is understood that for coverages other than medical, 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 the number of hours in the normal work week established by this planholder (but not less than 30 hours per week), at this planholder's place of business. It is further understood that no agent has power on behalf of Guardian to make or modify any request of application for Insurance, or to bind said Insurance Company by making any promise or representation or by giving and receiving any information.

It is further understood that no insurance will be effective until the final offer of plan and rates by Guardian is accepted, in writing, by the employer. No contract of insurance is to be implied in any way on the basis of completion and submission of this application.

Any person who, with intent to defraud or knowing that he 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.

I have reviewed the statements made by me on this application, and to the best of my knowledge and belief, they are true and complete.

Signature and Title of Officer, Partner, Proprietor Date

 Please **print** name of Officer, Partner, Proprietor

 Signature of Witness Date

PLAN SPECIFICATIONS

SECTION VI: LIFE INSURANCE (Attach supplemental application for Opt. Life GG-012623/OPT and/or Basic Life GG-012623/Life)

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

CLASSIFICATIONS	LIFE & AD&D	OPTIONAL	STD	LTD

BASIC TERM LIFE: Evidence of Insurability: Amount in Excess of \$ _____

- REDUCTION: 35% @ age 65, 25% @ age 70
 15% @ age 75 and 10% @ age 80
 35% @ age 65 and 15% @ age 70
 Other: _____

Common Carrier: Yes No

REDETERMINATION: (If based on earnings) Immediate Anniversary Other:

BASIC DEPENDENT LIFE: Spouse \$ _____ Child, 14 days to 6 months \$ _____ Child, 6 months to age _____ \$ _____

SECTION VII: MEDICAL PLANS

SELECTED MEDICAL PLANS CODE: (Please refer to Plan Matrix)	PRESCRIPTION DRUG RIDERS:
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HCS PPO is only available for employees residing outside of the Health Net service area if the group has 50% or less of their employees residing outside of the service area. PHCS PPO is only available for employees residing outside of the Health Net service area if the group has more than 50% of their employees residing outside of the service area.

(For Guardian and Health Net Use Only) Limitation of Pre-Existing Condition for PPO Plans: Included No Loss/No Gain

PPP Plan Code(s) and Location(s): _____

QUOTED RATES:

HMO	POS	HCS PPO	PHCS PPO	PRESCRIPTION DRUG
SINGLE:	SINGLE:	SINGLE:	SINGLE:	SINGLE:
FAMILY:	FAMILY:	FAMILY:	FAMILY:	FAMILY:
EMP/SP:	EMP/SP:	EMP/SP:	EMP/SP:	EMP/SP:
EMP/CH:	EMP/CH:	EMP/CH:	EMP/CH:	EMP/CH:

Indicate whether the benefits listed below will be administered on a contributory or non-contributory basis:

EMPLOYEE COVERAGES	CONTRIB.	NON-CONTRIB.	DEPENDENT COVERAGE	CONTRIB.	NON-CONTRIB.
LIFE & AD&D			LIFE		
MEDICAL			MEDICAL		
DENTAL			DENTAL		
SHORT TERM DISABILITY			Indicate % of employer contribution towards disability:		
LONG TERM DISABILITY			Short Term Disability _____% Long Term Disability _____%		

SECTION VIII: DENTAL BENEFITS (Attach supplemental application GG-012623/DEN)

DEDUCTIBLE: \$ _____	FAMILY MAXIMUM: _____	DEDUCTIBLE WAIVED: <input type="checkbox"/> YES <input type="checkbox"/> NO FOR <input type="checkbox"/> PREVENTIVE <input type="checkbox"/> BASIC <input type="checkbox"/> MAJOR			
<input type="checkbox"/> DENTAL GUARD PLAN:	PREVENTIVE	BASIC	MAJOR	ORTHO	
	CO-INSURANCE: _____%	_____%	_____%	_____%	_____%
<input type="checkbox"/> PPO <input type="checkbox"/> Indemnity	IN-NETWORK: _____%	_____%	_____%	_____%	_____%
<input type="checkbox"/> PPO Plan Type:	OUT-OF-NETWORK: _____%	_____%	_____%	_____%	_____%
	ORTHODONTIA: <input type="checkbox"/> YES <input type="checkbox"/> NO	LIFETIME DEDUCTIBLE: \$ _____	LIFETIME MAXIMUM: \$ _____		

SECTION IX: EMPLOYEE DISABILITY BENEFITS (Attach supplemental application GG-012623/STD and/or GG-012623/LTD)

Short Term Long Term: (see supplemental application)

Class _____ % of salary _____ to \$ _____

Class _____ % _____ to \$ _____

Elimination: _____ Accident Sickness

Elimination: _____ Accident Sickness

Benefit Duration: _____ Accident Sickness

Benefit Duration: _____ Accident Sickness

Tax Identification # _____

Maternity covered as any other illness

