

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: (15th 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): 15th 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 \$
Elimination Period: Accident		Sickness	Elimination Period: Accident		Sickness
Benefit Duration: Accident		Sickness	Benefit Duration: Accident		Sickness
Tax Identification #:					
If Plan Includes Long Term Disability Complete the Following:			Length of time in business (years):		
Benefit Reduction: <input type="checkbox"/> Direct Primary <input type="checkbox"/> All Sources 70% (Full)			Redetermination: 15 th of the month following date of approval.		
Pre-existing Conditions: *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 _____