Your Insurance Broker is : **Broker Name** ____________________
Broker Address:
____
____
____
Broker Phone:
____

Your Guardian Representative is : **GR Name**____________________
GR Address:
____
____
____
GR Phone:
____

The Guardian Life Insurance Company Of America | **Home Office Address** 7 Hanover Square, New York, NY 10004

APPLICATION FOR A PLAN OF GROUP INSURANCE

REQUESTED COVERAGE			
Applicant Name :			Coverage(s): **Dental** **Vision** **Short Term Disability** **Long Term Disability** **Life**
Address :			
City :			
State :	Zip :	SIC Code :	

BUSINESS INFORMATION		
Types of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ S Corp ☐ Other: ____________________	Nature of Business	
	Tax ID Number	Date Established MM/DD/YYYY
☐ Yes ☐ No Has your company ever filed, or is it now in the process of filing, for bankruptcy (Chapter 7 or 11) ?		
Complete below if your company or any of its affiliates has ever applied for group insurance with Guardian.		
Company or Affiliate Name (If different from Section 1)	Plan Number	Cancellation Date MM/DD/YYYY
Worker's Compensation: Present Carrier Name: List Owners/Partners NOT Covered by Workers' Compensation:		
☐ Yes ☐ No ☐ N/A If present carrier provides life insurance, are extended benefits provided in case of disability?		
Complete below if there are any COBRA or state continuation cases.		

Employee/Dependent		**Type**	**Reason**	**Continuation Dates**	
	Date of Birth MM/DD/YYYY	☐ State ☐ Federal ☐ Extension of benefits	☐ Disability ☐ Non-Disability	Start MM/DD/YYYY	End MM/DD/YYYY

For additional names, please attach a separate sheet

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HEALTH RELATED INFORMATION

Answer the following questions to the best of your knowledge for any members to be insured. The term "member" means eligible employees and their dependents and COBRA participants and their dependents. Provide details for any "Yes" response on a separate sheet. Do not disclose the name of any member.

The information obtained in answer to the following questions will not be used to deny enrollment to any individual member or to affect an individual member's eligibility for medical or prescription drug coverage in any way.

☐ Yes ☐ No	**Groups with less than 50 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, liver disorder, stroke, or other serious or debilitating illness?
☐ Yes ☐ No	Have any members been absent from work for more than 10 consecutive days due to illness or injury during the past 12 months?
☐ Yes ☐ No	Are any employees currently not actively at work? If Yes, please complete the supplemental Actively at Work statement.

AGREEMENT

Conditions Of Agreement
It is understood that only full-time employees shall be eligible.

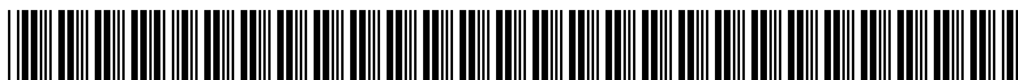
Full-time employee means one who regularly works the number of hours in the normal work week established by this applicant (but not less than 30 hours per week) at the applicant's normal place of business.

Insurance Broker Representation: It is further understood that no broker has power on behalf of The Guardian Life Insurance Company 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 and receiving any information.

Acceptance of Plan
It is further understood that no insurance will be effective until the plan is accepted in writing by the Insurance Company(-ies). No contract of insurance is to be implied in any way on the basis of the completion and submission of the application.
Upon acceptance, this application will be attached to and made part of the Group Insurance Policy.

FRAUD WARNING:
For Coverages other than Life Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The undersigned applicant certifies that to the best of his/her knowledge and belief, all of the responses given are true, correct and complete. The applicant understands that a false statement or misrepresentation in the application may result in loss of coverage in the policy, the rescission of the policy, or a revision of the rates quoted.
For Life Insurance Coverage:
The undersigned applicant states that, to the best of his/her knowledge and belief, all of the responses given are true, correct and complete. The applicant understands that the policy herein applied for is incontestable after 2 years from its date of issue, except for nonpayment of premiums



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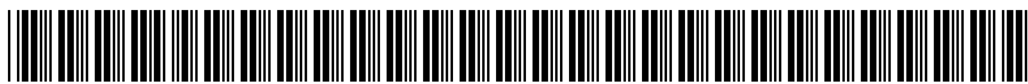
AGREEMENT Continued	
	by the policyholder. The applicant also understands that no statement made by any person insured under the policy relating to that person's insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of 2 years during such person's lifetime; and in no event unless it is in a written instrument signed by the person, a copy of which is or has been furnished to such person or to the person's beneficiary.

SIGNATURES			
I have reviewed the statements made by me on this application, and they are true and complete to the best of my knowledge and belief. By my signature below, I acknowledge that ____________________________________ endorses the Guardian plan of insurance.			
Officer, Partner or Proprietor Signature		Witness Signature	
X	Date MM / DD / YYYY	X	Date MM / DD / YYYY
Title		Title	
Insurance Broker Signature		Additional Insurance Broker Signature	
X	Date MM / DD / YYYY	X	Date MM / DD / YYYY
Print Name		Print Name	
CMA2007 - NY			

Group Plan Number ______________________ Requested Effective Date MM / DD / YYYY



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