



Northeast Regional Office
PO Box 26040
Lehigh Valley PA 18002-6040

Midwest Regional Office
PO Box 8012
Appleton WI 54912-8012

Western Regional Office
PO Box 2454
Spokane WA 99210-2454

Bridgewater Office
PO Box 425
E. Bridgewater MA 02333-0425

**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

Number 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 full-time emp's
in this company

No. of full-time 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. If present carrier provided life insurance, are extended benefits provided in case of disability? Yes No

4. 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

5. **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; AIDS; AIDS Related Complex; or other serious disease? Yes No

6. **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

City and State Where Signed: