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Spokane, WA 99210-2454

**SPECIFICATIONS FOR A NON  
MEDICAL PLAN OF GROUP  
INSURANCE - NEW YORK**

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

No. 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 f/t emp's in this company	No. of f/t 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:  Yes  No  
 actively at work     on disability leave/claim     other (please provide details on back of form)

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

If any questions in Section II of this form were answered "yes", please provide an explanation using the additional space below. Refer to the specific question number, and give details including names where appropriate. If additional space is needed, use a separate sheet of paper, and refer to the question number. Be sure to sign, date and have it witnessed.

Question No.	Explanation

**SECTION III COVERAGE ELECTION**

**Insurance to be issued: "N" for non contributory or "C" for contributory. If "C" indicate % of employee contribution.**

Employee:	Life	%	Dental	%	Vision	%	STD	%	LTD	%
Dependent:	Life	%	Dental	%	Vision	%				

**SECTION IV AGENT INFORMATION**

# 1) Agent Name: \_\_\_\_\_ % \_\_\_\_\_ Code: \_\_\_\_\_ Guardian Agency: \_\_\_\_\_ Code: \_\_\_\_\_

Agent Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Tax ID # \_\_\_\_\_

# 2) Agent Name: \_\_\_\_\_ % \_\_\_\_\_ Code: \_\_\_\_\_ Guardian Agency: \_\_\_\_\_ Code: \_\_\_\_\_

Agent Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Tax ID # \_\_\_\_\_

Sales Office \_\_\_\_\_ Sales Representative \_\_\_\_\_ Code \_\_\_\_\_

**SECTION V AGREEMENT**

**Request for Participation In A Certain Trust Agreement**  
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 III.

**Conditions of Agreement**  
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.

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.

I have reviewed the statements made by me on this application, and they are true and complete.

Signature and Title of Officer,  
Partner or Proprietor: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Officer, Partner  
or Proprietor: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

City and State Where Signed: \_\_\_\_\_