

# GROUP APPLICATION

Insured by: GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (GLIC)



EMPLOYER GROUP INFORMATION			
FULL LEGAL NAME OF COMPANY			
TYPE OF BUSINESS		HOW LONG IN BUSINESS	
COMPANY CONTACT	E-MAIL ADDRESS	TELEPHONE #	FAX #
STREET ADDRESS		CITY	STATE ZIP
BILLING ADDRESS (IF DIFFERENT)		CITY	STATE ZIP
EMPLOYER CONTRIBUTION (MINIMUM OF 50%) EMPLOYEE: _____% DEPENDENT: _____%		TAX ID NUMBER:	

ELIGIBILITY INFORMATION	
1. Probationary Period for New Hires / Rehires – First of the month following:	<input type="checkbox"/> Date of hire <input type="checkbox"/> 1 mo. <input type="checkbox"/> 2 mos. <input type="checkbox"/> 3 mos. <input type="checkbox"/> _____ mos. (6 max.)
2. Number of hours worked per week required to be eligible for medical insurance coverage:	<input type="checkbox"/> 20 <input type="checkbox"/> 30
3. Number of Eligible Employees ( <u>including</u> eligible owners)	_____
4. Total Number of Enrollees ( <u>excluding</u> COBRA enrollees)	_____
5. Number of COBRA Enrollees (applying for health coverage)	_____
6. Number of Waivers (Please attach "Declination of Coverage" form)	_____
7. Has the employer ever held a GLIC Contract?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Do the eligible enrollees represent a carve-out either by class, location, or union affiliation?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Do you currently have group dental benefits?	<input type="checkbox"/> YES <input type="checkbox"/> NO Carrier Name: _____ Renewal Date: _____

WE ARE APPLYING FOR THE FOLLOWING PLAN(S):	
Dental:	HMO – <input type="checkbox"/> Low-Option <input type="checkbox"/> High-Option PPO – <input type="checkbox"/> 1500 Standard <input type="checkbox"/> 1500 UCR <input type="checkbox"/> 2000 Standard <input type="checkbox"/> 2500 UCR
Term Life: \$ _____	REQUESTED EFFECTIVE DATE: _____

AGREEMENT			
<p>Please complete all of the information requested before signing this application. Please initial any changes.</p> <p>It is understood that only employees and dependents of such shall be eligible.</p> <p>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.</p> <p>Upon acceptance, this application will be attached to and made part of the Group Insurance Policy.</p> <p>Any person, who with intent to defraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.</p> <p>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.</p> <p><b>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 AAQHC, An Administrator, endorses the Guardian plan of insurance.</b></p>			
<table border="1"> <tr> <td>OFFICER OF THE COMPANY SIGNATURE</td> <td>OFFICER TITLE</td> <td>DATE</td> </tr> </table>	OFFICER OF THE COMPANY SIGNATURE	OFFICER TITLE	DATE
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**STATEMENT OF AGENT OR REPRESENTATIVE**

I, or we, have complied with the underwriting rules and regulations of Guardian Life Insurance Company of America (GLIC), and have explained to the new applicant, in detail, the coverages and provisions of the plans. To the best of my knowledge and belief, all statements on the Employer Application are complete and true. **I have advised my client not to terminate any existing coverage until this application is accepted.** It is further understood that no broker has the power on behalf of GLIC 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.

<b>BROKER NAME</b>	<b>BROKER ID #</b>	<b>BROKER LICENSE #</b>	<b>DATE SUBMITTED</b>
<b>AGENCY NAME</b>	<b>TELEPHONE #</b>	<b>FAX #</b>	<b>E-MAIL ADDRESS</b>
<b>ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>BROKER / CONSULTANT SIGNATURE</b>			<b>DATE</b>