



The Guardian Life Insurance Company of America

Specification for a Plan of Group Insurance

Managed Dental Care of California
A wholly owned subsidiary of Guardian

Please Print

New Plan

Change of Plan

GROUP PLAN NUMBER (Guardian Use Only)

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 (or statutory requirement) Other _____ (min. 17.5 hrs/wk)

Number of full-time employees: _____ Number 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:

(Groups of 50 or fewer lives: All eligible employees must be included for medical coverage unless statutorily permitted to exclude based solely on conditions of employment)

Premium Paid Monthly Quarterly Annual Semi Annual GOM

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 GIAC? Yes No If "yes", furnish name of employer/company, plan number and date of cancellation:

2. Name of present or prior group carrier:

Cancellation Date:

3. Does your firm have any other insurance plan: A) now in force and to be continued? Yes No B) that you are currently applying for? Yes No If "yes", give description of plan and name of carrier(s):

4. What coverages are now or were in force: Life Medical Prescription Drugs Dental Vision Short Term Disability Long Term Disability (Please attach copies of booklet and current billing statement)

5. If present carrier provided life insurance, are extended benefits provided in case of disability?

Yes No

6. If present carrier provided health insurance, are extended benefits provided in case of termination of the master plan?

Yes No

7. A) 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

B) Are any dependent children incapable of self-support because of a physical or mental disability?

Yes No

8. For plans with less than 50 employees: To the best of your knowledge has any employee or dependent (active or on continuation) been treated for or diagnosed as having: cancer; heart disease; kidney disorder; stroke; liver disease; chronic obstructive lung disease; diabetes; neurological disorders or diseases; AIDS (Acquired Immune Deficiency Syndrome); or AIDS Related Complex?

Yes No

9. To the best of your knowledge has any employee or dependent (active or on continuation) suffered a condition which resulted in a health claim of \$10,000 (\$20,000 for groups with 150 or more eligible employees) or greater during the past two years?

Yes No

10. To the best of your knowledge: Are there any current or former employees or their eligible dependents whose health insurance is being continued? If "yes", complete the information on the reverse side of this application for each current/former employee or dependent on health continuation.

Yes No

BE CERTAIN TO READ THIS ENTIRE APPLICATION, THEN SIGN, DATE AND HAVE IT WITNESSED ON THE REVERSE SIDE

If question number 10 was answered "yes", complete information below:

Employee/Dependent	D/O/B	Type of Continuation State/Federal/Extended Benefits	Reason for Termination Disability/Non Disability	Continuation Dates Start End

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.

Ques. No.	Name	Status of Insured*	Medical Expenses for the last 12 Months	Diagnosis	Prognosis	Home Office Use Only

*Status: E = Employee D = Dependent C = Continuation

SECTION III > COVERAGE ELECTION (For each coverage selected, please attach a supplemental application)

Insurance to be issued on the following basis. Indicate N for non contributory: If Contributory, indicate % of employee contribution.

Employee:	Life %	Maj. Med. %	Rx Drug %	Dental %	Vision %	STD %	LTD %
Dependent:	Life %	Maj. Med. %	Rx Drug %	Dental %	Vision %		
Supplements:	GG-012623/Life	GG-012623/Med	GG-012623/PDB	GG-012623/Den	GG-012623/Vis	GG-012623/STD	GG-012623/LTD

SECTION IV > AGENT

1) Agent Name: _____ % _____ Code: _____ Guardian Agcy: _____ Code: _____

Agent Address: _____
 Street City State Zip Code

Agent Signature _____ Soc. Sec. # _____ License# _____ Tax ID# _____

2) Agent Name: _____ % _____ Code: _____ Guardian Agcy: _____ Code: _____

Agent Address: _____
 Street City State Zip Code

Agent Signature _____ Soc. Sec. # _____ License# _____ Tax ID# _____

Sales Office _____ Sales Representative _____

SECTION V > AGREEMENT

(For Guardian use only- RI Trust case Yes No; If "yes", the following provision applies)

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 above.

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 the number of hours in the normal work week established by this planholder (but not less than 30 hours per week or as provided by state law) at the planholder's normal 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. (** Based on statutory requirements, this "actively at work" requirement will be waived for major medical insurance. Check with Guardian for details.) 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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud, as determined by a court of law."

In California, pre-paid dental coverage is underwritten by Managed Dental Care of California, Inc., 6200 Canoga Avenue, Suite 100, Woodland Hills, California, 91367, a wholly owned subsidiary of Guardian. All other coverages are underwritten by The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004.

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: _____

Plan Number: _____

A. Class Structure

List Class Description(s) of Eligible Employees

Class No.	Class Description

B. Waiting Period *(If waiting period varies by coverage/s, please specify in Remarks.)*

1) **Present employees:** Employees hired on or prior to the date this insurance plan is effective with Guardian.

- None
- First of the month following _____ days or _____ months of employment.
- _____ days following employment
- _____ months following employment
- Other _____

2) **Future employees:**

- None
- First of the month following _____ days or _____ months of employment.
- _____ days following employment
- _____ months following employment
- Other _____

C. Earnings Definition *(If class is based on salary)*

- Standard excluding bonuses and commissions _____ Class(es)
- Standard including bonuses and commissions _____ Class(es)
- Standard including bonuses _____ Class(es)
- Standard including commissions _____ Class(es)
- W-2 definition _____ Class(es)
- Other _____ Class(es)

D. Earnings Redetermination *(If class is based on salary)*

(Does not apply to Optional Life coverage.)

- Immediately _____ Class(es)
- Anniversary Date _____ Class(es)
- Other _____ Class(es)

E. **Enrollment Complete?** Yes No, Additional enrollment forms to follow.

F. **Employee Assistance Program** Yes No
 Standard
 Enhanced (pilot offices only)

- Sold with single line of coverage (must be non-voluntary)
- Sold with 2 or more lines of coverage (at least one must be non-voluntary)
 - Medical Prescription Drug Dental
 - Basic Life STD LTD
 - Full Service Vision

G. **Enrollment Success Plan**

Did the plan utilize the Enrollment Success Program (ESP)? Yes No If yes, please indicate coverages below.

- Plan must meet all of the current ESP Guidelines or receive approval from Underwriting
- Copy of ESP agreement must be sent to Field Support
(Note: Please refer to ESP Check List for Guidelines & Requirements)

Dental Vol Life Basic Life STD LTD Medical Rx

H. **Miscellaneous**

1) Retiree benefits:

- a) Present employees covered
 Present and future employees covered (future employees require a separate class)
- b) Age limitations _____
Length of service _____
Definition of a retiree _____
- c) List coverages that retirees will be eligible for:

d) Grandfathered Retirees Yes No

2) Print the name of the underwriter who quoted this plan: _____

3) Sales Support Associate: _____ Phone: _____

4) Contact for additional information: Planholder Broker Other _____

Name _____ Title _____

Address _____

Email Address: _____ Phone: _____ Fax: _____

I. **Master Application Signed By** _____ (Printed)

Title _____

Remarks