GUARDIAN®

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

ADDITIONAL INFORMATION QUESTIONNAIRE

Company Name	Plan Number	Requested Effective Date
Correspondent Name	Phone Number	Fax Number
Correspondent Title	Email Address	
Company Address	Mailing Address (if different)	
Total Number of Employees (Including Part-time)	Total Number of Employees Eligible for Coverage	Total Number of Employees Electing Coverage

Are there any Additional Company Locations? ☐ Yes (Please provide details) ☐ No (All out of state employees commute or work at home)

1. Company Location	Address		Total Employed	Eligible for Coverage
Correspondent Name	Phone Number	Email Address	Fax Number	

Please provide waiting period information.

Applies to:	☐(1) ☐(2)	Only employees hired <u>after</u> the effective date All employees including those hired <u>before</u>, <u>on</u>, or <u>after</u> effective date
Waiting Period:	☐(A) ☐(B) ☐(C) ☐(D) ☐(E)	_____ days (actual days counted) _____ month(s) first of the month following _____ days (actual days counted) first of the month following _____ month(s) first of the month following or coinciding with date hired
Coverage Ends:	First of the month effective dates give employees coverage until the end of the month for dental, medical and vision. Coverage ends immediately upon termination for life, disability critical illness and when employees are <u>not</u> effective on the first of the month.	

Requested Class Definitions.

Class	Description	Waiting period: *If class specific, indicate letter and number from waiting period section*	Earnings and Benefit Redetermination
Class 1	☐ All eligible employees	Applies to: ☐ 1 ☐ 2 Waiting Period: ☐ A ☐ B ☐ C ☐ D ☐ E	☐ Immediate: notify Guardian every time an employee's salary changes ☐ Plan Anniversary: updated yearly on ***plan's*** anniversary date ☐ Other determined by employer as described here (i.e. W2) _____
Class 2		Applies to: ☐ 1 ☐ 2 Waiting Period: ☐ A ☐ B ☐ C ☐ D ☐ E	☐ Immediate: notify Guardian every time an employee's salary changes ☐ Plan Anniversary: updated yearly on ***plan's*** anniversary date ☐ Other determined by employer as described here (i.e. W2) _____
Class 3		Applies to: ☐ 1 ☐ 2 Waiting Period: ☐ A ☐ B ☐ C ☐ D ☐ E	☐ Immediate: notify Guardian every time an employee's salary changes ☐ Plan Anniversary: updated yearly on ***plan's*** anniversary date ☐ Other determined by employer as described here (i.e. W2) _____

Please indicate any classes to be excluded. _____
Final classes may be altered based on legal requirements or ease of administration.

Does the company offer coverage for Domestic Partners? ☐ Yes ☐ No
If yes, check all that apply: ☐ same sex ☐ opposite sex ☐ children of domestic partner

Employer Contribution

Please complete this table listing the percentage of premium the employer pays

STD	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
LTD	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
Life	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
Voluntary Life	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
ADD	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
Dental	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
Vision	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
Medical	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
Critical Illness	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
Other	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none

If LTD, STD or CI is sold as Contributory or Voluntary, please indicate employee contribution: ☐ Pre-Tax ☐ Post-Tax

Hourly Work Requirement: Minimum hours per week (30 hours is standard).

☐ 30+ hours per week ☐ 40+ hours per week

Please provide prior carrier information (include a copy of each prior carrier's book and bill).

	Insert carrier name or select 'none'		Termination Date
Dental	☐	☐ none	__/__/____
Life	☐	☐ none	__/__/____
Medical	☐	☐ none	__/__/____
STD	☐	☐ none	__/__/____
LTD	☐	☐ none	__/__/____
Critical Illness	☐	☐ none	__/__/____

Open Enrollment Period ***(for dental, vision, and medical only)***

*Open Enrollment is only available when a Section 125 is in place.

	Sign up period begins and ends		Change Effective
	From Date	To Date	Transfer Date
Dental	____/____	____/____	____/____
Vision	____/____	____/____	____/____
Medical	____/____	____/____	____/____

Master Application signed by:_____ Title:_____

printed name

Billing Preferences

Guardian's standard billing method is electronic bills. You will receive e-bills for viewing and payment through our secure website www.GuardianAnytime.com. This option allows the waiving of the monthly administration fee. If you require a paper bill, please indicate below.

Billing frequency: Monthly Quarterly Semi-Annual Annual

Include Payroll Deduction Statements? ☐ Yes ☐ No

Payroll frequency: 12/year 24/year 26/year 48/year 52/year

Bill delivery ☐ electronic (standard) ☐ paper with volumes ☐ paper without volumes

☐ Standard List Bill - alphabetically by employee

☐ Subtotal billing **Organize by (Check one):** ☐ Class
☐ Job title
☐ Department
☐ Location
☐ By these codes (Up to 4 characters):

____ ____ ____ ____ _____
____ ____ ____ ____ _____
____ ____ ____ ____ _____
____ ____ ____ ____ _____

Insurance Broker Information (Broker Use Only)

Insurance Broker Name:		License Number	SSN
Address	City		State Zip Code
Phone Number	Fax Number	Email Address	
Broker Code	Agency Code	Agency Name	
Tax ID#	Commissions Split %	Pay to Broker	Pay to Agency

☐ **Additional Insurance Broker Name** ☐ **Sub Producer (choose one)**		License Number	SSN
Address	City		State Zip Code
Phone Number	Fax Number	Email Address	
Broker Code	Agency Code	Agency Name	
Tax ID#	Commissions Split %	Pay to Broker	Pay to Agency