Please print clearly to ensure accurate processing

GUARDIAN®

Your Insurance Broker is :

Broker Name _____
Broker Address:
_____
_____
_____
Broker Phone:
_____

Your Guardian Representative is :

GR Name_____
GR Address:
_____
_____
_____
GR Phone:
_____

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

APPLICATION FOR A PLAN OF GROUP INSURANCE

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

REQUESTED COVERAGE

Applicant Name :			Coverage(s): **Dental**
Address :			
City :			
State :	Zip :	SIC Code :	

BUSINESS INFORMATION

Types of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ S Corp ☐ Other: _____	Nature of Business	
	Tax ID Number	Date Established MM/DD/YYYY

☐ Yes ☐ No Has your company ever filed, or is it now in the process of filing, for bankruptcy (Chapter 7 or 11) ?

Complete below if your company or any of its affiliates has ever applied for group insurance with Guardian.

Company or Affiliate Name (If different from Section 1)	Plan Number	Cancellation Date MM/DD/YYYY

Complete below if there are any COBRA or state continuation cases.

Employee/Dependent		Type	Reason	Continuation Dates	
	Date of Birth MM/DD/YYYY	☐ State ☐ Federal ☐ Extension of benefits	☐ Disability ☐ Non-Disability	Start MM/DD/YYYY	End MM/DD/YYYY

For additional names, please attach a separate sheet

AGREEMENT

Conditions Of Agreement	**Acceptance of Plan**
It is understood that only full-time employees shall be eligible.	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

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AGREEMENT Continued

Full-time employee means one who regularly works the number of hours in the normal work week established by this applicant (but not less than 30 hours per week) at the applicant's normal place of business.

Insurance Broker Representation: It is further understood that no broker has power on behalf of The Guardian Life Insurance Company 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 and receiving any information.

any way on the basis of the completion and submission of the application.
Upon acceptance, this application will be attached to and made part of the Group Insurance Policy.

Fraud Warning:
Any person, who with intent to defraud or knowing that he/she 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.

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.

SIGNATURES

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 _____ endorses the Guardian plan of insurance.

Officer, Partner or Proprietor Signature		Witness Signature	
X	Date MM / DD / YYYY	X	Date MM / DD / YYYY
Title		Title	
Insurance Broker Signature		Additional Insurance Broker Signature	
X	Date MM / DD / YYYY	X	Date MM / DD / YYYY
Print Name		Print Name	

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Group Plan Number _____ Requested Effective Date MM / DD / YYYY

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