GUARDIAN®

The Guardian Life Insurance Company Of America

ADDITIONAL INFORMATION QUESTIONNAIRE

Company Name (As it should appear on your bill and contract)			Plan Number	Requested Effective Date
Correspondent Name			Phone Number	Fax Number
Correspondent Title			Email Address	
Company Address			Mailing Address (if different)	
City	State NY	Zip	City	State Zip
Total Number of Employees (Including Part-time)			Total Number of Employees Eligible for Coverage	Total Number of Employees Electing Coverage

Are there any Additional Affiliate Locations? ☐ Yes (Please provide details, including name if different than company name)
☐ No (All out of state employees commute or work at home)

Guardian is able to arrange incidental group coverage for US-sitused corporations in most countries. Depending on the countries where your employees are located, there may be a certain set of restrictions or exclusions applicable to benefit plans.
Do you have any employees working outside the United States? ☐ Yes ☐ No

If Yes, please provide details regarding the number of employees, and locations.

1. Affiliate Name	Address		Total Employed	Eligible for Coverage
Correspondent Name	Phone Number	Email Address	Fax Number	
2. Affiliate Name	Address		Total Employed	Eligible for Coverage
Correspondent Name	Phone Number	Email Address	Fax Number	
3. Affiliate Name	Address		Total Employed	Eligible for Coverage
Correspondent Name	Phone Number	Email Address	Fax Number	
4. Affiliate Name	Address		Total Employed	Eligible for Coverage
Correspondent Name	Phone Number	Email Address	Fax Number	

Please provide waiting period information.

Applies to:	☐(1)	Only employees hired after the effective date of coverage with Guardian
	☐(2)	All employees including those hired before, on, or after the effective date of coverage with Guardian

Waiting period information continued.

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 and vision. Coverage ends immediately upon termination for life, disability, specified disease 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) _____

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

Class(es) _____ Are class employees eligible for all coverages? ☐Yes ☐No
If no, what coverage(s) are to be excluded? _____

Coverage	Earnings Definition
Basic Life (if based on salary)	☐ Standard Excluding Bonus & Commission ☐ Standard Including Bonus ☐ Standard Including Commission ☐ Standard Including Bonus & Commission ☐ W-2 Preceding Calendar Yr. ☐ W-2 Preceding Tax Yr. ☐ Partnership/Subchapter S (Tax Year or Calendar Year) ☐ Sole Proprietorship ☐ Other_____
Voluntary Life (if based on salary)	☐ Standard Excluding Bonus & Commission ☐ Standard Including Bonus ☐ Standard Including Commission ☐ Standard Including Bonus & Commission ☐ W-2 Preceding Calendar Yr. ☐ W-2 Preceding Tax Yr. ☐ Partnership/Subchapter S (Tax Year or Calendar Year) ☐ Sole Proprietorship ☐ Other_____

Does the company offer coverage for Domestic Partners? ☐ Yes ☐ No
☐ 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
Basic 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
Specified Disease	Employee	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part _____%	☐ Employer pays none

Hourly Work Requirement: Minimum hours per week (30 hours is standard).
☐ 30+ hours per week ☐ 40+ hours per week

Please provide prior carrier information

	Insert carrier name or select 'none'		Termination Date
Dental	☐	☐ none	_ _/_ _/_ _ _ _
Basic Life	☐	☐ none	_ _/_ _/_ _ _ _
Voluntary Life	☐	☐ none	_ _/_ _/_ _ _ _
STD	☐	☐ none	_ _/_ _/_ _ _ _
LTD	☐	☐ none	_ _/_ _/_ _ _ _
Specified Disease	☐	☐ none	_ _/_ _/_ _ _ _

Open Enrollment Period *(for dental and vision 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	____/____	____/____	____/____

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 ☐ 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):
0 0 0 0 DESCRIPTION
___ ___ ___ ___ _____
___ ___ ___ ___ _____
___ ___ ___ ___ _____
___ ___ ___ ___ _____

Delivery Preference of Plan Materials.

ID Cards:

Electronic Member Level ID Cards or Electronic Plan Level ID Cards are available on Guardian Dental and Fully Insured Davis and VSP plans. These are accessible through our Guardian Anytime Website (www.guardiananytime.com)

Would you like Plan Level or Member Level Electronic Cards? ☐ Plan Level ☐ Member Level

☑ Electronic Cards

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

Guardian Group Sales Use Only

Vision Access

If you have selected Vision, do you wish to also include Vision Access?

☐ Yes ☐ No

VSP Vision Plan Type A1

DentalGuard IV/2000 Maximum Allowable Charge: 10

Tied Coverages

☐ Yes ☐ No

If yes, please indicate tied coverages and those tied to another carrier: _____

Is Optional Accidental Death & Dismemberment (ADO) tied to Voluntary Life? ☐ Yes ☐ No

If Yes, does the ADO amount need to match the Voluntary Life amount? ☐ Yes ☐ No

Grandfather Current Amounts

☐ Yes ☐ No

If yes, please include a copy of prior carrier bill, showing amounts to be grandfathered, and underwriter approval.

Combined/Block plans (for Phoenix coding)

Combined w /_____ (Parent #)
Block w / _____ (name of block)
Tied To G#_____
☐ N/A

ID Cards

Your planholder cards are set up for electronic distribution (no print). If the planholder requires printed cards, please check Printed Cards option and complete the information below.

☑ **Electronic only**

☐ **Printed Cards**

***If no boxes are checked below, we will process the card order as electronic.**

Please provide details for printed cards: (Please select one: Plan level or Member level)

☐ Plan level Ship to: ☐ Company ☐ Division ☐ TPA ☐ Other_____

☐ Member level Ship to: ☐ Employee's home ☐ Company ☐ Division ☐ TPA ☐ Other_____

Were up-front printed cards already ordered by the RGO? ☐ Yes ☐ No

Remarks (Explain any non-standard benefits here)