



The Guardian Life Insurance Company of America
 Health Net of New York, Inc.
 PO Box 26050
 Lehigh Valley, PA 18002-6050

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Application for a Plan of Insurance and Plan Specifications

Please Print PLAN NUMBER (Guardian and Health Net Use only):

New Plan Change of Plan Requested effective date:

SECTION I: PLANHOLDER INFORMATION

Planholder (full legal name of company): Tax ID #:

Main Address (street, city, state, zip):

Mailing Address (street, city, state, zip):

Email Address: Fax No.: () Phone No.: ()

Name of correspondent: Title:

Type of organization: Corporation Partnership Proprietorship Other (explain):

Total number of employees: No. of full-time employees: No. of full-time employees to be insured:

Deposit \$ Nature of Business (specify): Date established: SIC:

Waiting period before employee becomes insured? Presently employed: Future:

Do you have any affiliates, subsidiaries or branches? Yes No

Affiliates, subsidiaries or branches (legal name & location)	Nature of business	No. of full-time emps. this company	No. of full-time emps. to be ins.

For Medical Coverage Only: 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 20 hours per week for groups subject to New York Small Group Reform, enrolled in the Guardian/Health Net (HMO, POS, Charter Traditions and HCS PPO) plans, and not less than 20 hours per week for groups, subject to New York Small Group Reform, enrolled in the PHCS PPO; but not less than 30 hours per week for groups not subject to New York Small Group Reform, enrolled in the PHCS PPO plan at the Planholder's normal place of business.
For all other coverages: 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) at the planholder's normal place of business.

SECTION II: SPECIFICATIONS FOR A PLAN OF GROUP INSURANCE

Are all full-time employees to be included? Yes No If "no," indicate class or classes to be excluded?

Percentage of employer contribution for medical coverage: Employee Coverage: % Dependent Coverage: %

SECTION III: 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 and/or The Guardian Insurance and Annuity Company. Yes No If "yes", furnish name of employer, plan number and date of cancellation:

2) If present carrier provided life insurance, are extended benefits provided in case of disability? Yes No

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): Limitations of Pre-Existing Conditions*
 (For Guardian Indemnity plans only)
 Included No Loss/No Gain
 *(For Guardian and Health Net use only)

4) Name of present or prior group carrier: Cancellation Date:

5) What coverages are now in force? Life Optional Life Medical Dental Prescription Drug STD LTD Vision
 (Please attach copies of booklets and current billing statements)

6) To the best of your knowledge, are there any current and former employees or their eligible dependents whose health insurance is being continued? Yes No Please provide the following information on health continuation for each current/former employee or dependent:

Employee/Dependent	D/O/B	Continuation State / Federal	Continuation due to Disability / Non-Disability	Continuation Dates Start / Expiration

SECTION IV: EXPERIENCE INFORMATION: For groups not subject to New York Small Group Reform or any group applying for life and/or disability coverage. (If additional space is needed, please complete on a separate sheet and attach)

To the best of your knowledge:

- 1) a. Are any employees or dependents presently incapacitated? Yes No
 b. Are any dependent children incapable of self-support because of a physical or mental disability? Yes No
- 2) For groups not subject to New York Small Group Reform, and for all groups APPLYING FOR LIFE AND/OR DISABILITY COVERAGE ONLY: Has any employee or dependent active or on continuation, ever been treated for or diagnosed as having cancer, heart disease, kidney disorder, stroke, AIDS, AIDS Related Complex or other serious disease? Yes No
- 3) If present or prior carrier provided health insurance, other than HMO or Point-of-Service, did any insured, active or on continuation suffer a condition which resulted in claims of \$10,000 or more in the past 2 years? Yes No
- 4) Has any employee been absent from work for 10 or more consecutive days due to illness or injury in the last 12 months? Yes No

If any questions in Section IV were answered "yes", please explain using the additional space designated "Detailed Explanations" on reverse side of this application. Refer to the specific question number, and give details (including names where appropriate).

Be certain to read this entire application/plan specifications: then sign, date, and have it witnessed on the reverse side.

PLAN SPECIFICATIONS

SECTION VI: LIFE INSURANCE (Attach supplemental application for Opt. Life GG-012623/opt and/or Basic Life GG-012623/Life) 3

6 Plan of Insurance (an employee is eligible only for the amount shown for his/her classification)

CLASSIFICATIONS	LIFE & AD&D	OPTIONAL 4	STD	LTD

BASIC TERM LIFE: Evidence of Insurability: Amount in Excess of \$ _____
 REDUCTION: 35% @ age 65, 25% @ age 70
 15% @ age 75 and 10% @ age 80
 35% @ age 65 and 15% @ age 70
 Other: _____
 Common Carrier: Yes No
 REDETERMINATION: (If based on earnings) Immediate Anniversary Other:
 BASIC DEPENDENT LIFE: Spouse \$ _____ Child, 14 days to 6 months \$ _____ Child, 6 months to age _____ \$ _____

SECTION VII: MEDICAL PLANS

SELECT MEDICAL: HMO POS Charter Traditions HCS PPO PHCS PPO*
 HCS PPO is only available for employees residing outside of the Health Net service area if the group has 50% or less of their employees residing outside of the service area. PHCS PPO is only available for employees residing outside of the Health Net service area if the group has more than 50% of their employees residing outside of the service area. PRESCRIPTION DRUG RIDERS:

(For Guardian and Health Net Use Only) Limitation of Pre-Existing Condition for PPO Plans: Included No Loss/No Gain

PLAN CODE(S): HMO _____ POS _____ Charter Traditions _____ HCS PPO _____ PHCS PPO _____

QUOTED RATES:

5	HMO	POS	Charter Traditions	HCS PPO	PHCS PPO	PRESCRIPTION DRUG
SINGLE:	SINGLE:	SINGLE:	SINGLE:	SINGLE:	SINGLE:	SINGLE:
FAMILY:	FAMILY:	FAMILY:	FAMILY:	FAMILY:	FAMILY:	FAMILY:
EMP/SP:	EMP/SP:	EMP/SP:	EMP/SP:	EMP/SP:	EMP/SP:	EMP/SP:
EMP/CH:	EMP/CH:	EMP/CH:	EMP/CH:	EMP/CH:	EMP/CH:	EMP/CH:

PHCS PPO coverage is not available to groups subject to small group reform, except for employees residing outside of the service area.

INDICATE WHETHER THE BENEFITS LISTED BELOW WILL BE ADMINISTERED ON A "C" CONTRIBUTORY OR "N" NON CONTRIBUTORY BASIS:

EMPLOYEE:
 LIFE: _____ MEDICAL: _____ DENTAL: _____ *VISION: _____ SHORT TERM DISABILITY: _____ LONG TERM DISABILITY: _____

DEPENDENT:
 LIFE: _____ MEDICAL: _____ DENTAL: _____ VISION: _____ INDICATE % OF EMPLOYER CONTRIBUTION: STD: _____ LTD: _____

*Attach supplemental application GG-012623/Vis for Vision Coverage 3

SECTION VIII: DENTAL BENEFITS (Attach supplemental application GG-012623/DEN) 3

DEDUCTIBLE: \$ _____ FAMILY MAXIMUM: _____ DEDUCTIBLE WAIVED: YES NO FOR PREVENTIVE BASIC MAJOR

DENTAL GUARD PLAN <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO: Plan Type _____ <input type="checkbox"/> NAP: Plan Type _____	PREVENTIVE	BASIC%	MAJOR%	ORTHO%
	CO-INSURANCE: _____ %	_____ %	_____ %	_____ %
IN-NETWORK: _____	_____ %	_____ %	_____ %	_____ %
OUT-OF-NETWORK: _____	_____ %	_____ %	_____ %	_____ %
ORTHODONTIA: <input type="checkbox"/> YES <input type="checkbox"/> NO	LIFETIME MAXIMUM:\$ _____			

SECTION IX: EMPLOYEE DISABILITY BENEFITS (Attach supplemental application GG-012623/STD and/or GG-012623/LTD) 3

Short Term Disability Long Term Disability
 Class _____ % of salary _____ to \$ _____ Class _____ % _____ to \$ _____
 Elimination: _____ Accident Sickness Elimination: _____ Accident Sickness
 Benefit Duration: _____ Accident Sickness Benefit Duration: _____ Accident Sickness
 Tax Identification # _____ Maternity covered as any other illness

SECTION X: REMARKS (Use this section for any additional information needed for Plan Specifications)

10 Coverage under the HMO, in-network portion of the Point-of-Service plan and Charter Traditions is provided by Health Net of New York, Inc. 399 Knollwood Road, White Plains, NY 10603. PHCS PPO coverage, the out-of-network portion of the Point-of-Service plan, and ancillary lines of coverage are underwritten by The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-2616.
 Guardian Indemnity Contract Number GP-1-R3-1.0 et al
 New York Out-of-Network POS Contract Number GP-1-JV-HCS-NY-1

FOR GUARDIAN AND HEALTH NET USE ONLY:

PLAN CODE _____ HMO PLAN CODE _____ POS
 PLAN CODE _____ CHARTER TRADITIONS PLAN CODE _____ PHCS PPO
 PLAN CODE _____ HCS PPO