

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.

Question No.	Explanation

SECTION II COVERAGE ELECTION

Insurance to be issued: "N" for non contributory or "C" for contributory. If "C" indicate % of employee contribution.

Employee:	Life	%	Dental	%	Vision	%	STD	%	LTD	%
Dependent:	Life	%	Dental	%	Vision	%				

SECTION III AGENT INFORMATION

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

Agent Address: _____
 Street _____ City _____ State _____ Zip Code _____

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

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

Agent Address: _____
 Street _____ City _____ State _____ Zip Code _____

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

Sales Office _____ Sales Representative _____ Code _____

SECTION IV AGREEMENT

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 in Section III.

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 at least the number of hours in the normal work week established by this Planholder (but not less than 30 hours per week) at his Planholder's 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.

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 knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I have reviewed the statements made by me on this application, and they are true and complete.

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: _____



GUARDIANSM

7 Hanover Square
New York, NY 10004

APPOINTMENT OF ADMINISTRATOR

("Planholder") _____,
with principal offices at _____,
appoints ("Administrator") Bene-Care Agency LLC ,
with principal offices at 500 Helendale Rd #175 Rochester NY 14609 ,
to administer Guardian group plan (G- _____) ("Plan"), effective _____.

Administrator shall act as Plan holder's agent in performing administrative services, including but not limited to (1) enrolling eligible employees and dependents, (2) notifying Guardian of terminations of coverage, (3) transmitting premium notices to Plan holder, (4) receiving premium from Plan holder and submitting same to Guardian, (5) delivering certificates, or, (6) maintaining enrollment cards.

Administrator shall have no authority to bind Guardian or to modify the Plan or waive any provision thereof.

Administrator agrees to indemnify and hold Guardian harmless from any and all losses caused by Administrator's negligence or willful misconduct. Administrator shall be bonded or insured, in an amount no less than one million dollars and for the protection of Guardian, for losses caused by acts of fraud, dishonesty, or negligence. Administrator shall deliver to Guardian evidence of the existence of such bond or insurance policy and shall notify Guardian, in writing, fifteen days prior to cancellation or material modification of such bond or insurance policy.

This appointment shall remain effective until the earliest of the following events:

- (1) cessation of Administrator's business;
- (2) bankruptcy, receivership or dissolution of Administrator;
- (3) negligence, fraud or embezzlement on the part of Administrator;
- (4) upon 30 days written notice by Plan holder to Guardian and Administrator;
- (5) upon termination of the Plan.

Termination of the Appointment shall not terminate any rights or liabilities arising out of a period prior to termination.

Date	Plan holder	By

Appointment Accepted:

Date	Administrator	By

Appointment Agreed to:

Date	The Guardian Life Insurance Company of America	By

2/1/02

Guardian Questionnaire

Company Name: _____

Plan Design Sold: _____ With Ortho? YES NO

Rates: _____

Waiting Period for future employees:

Any additional locations?: YES NO

If yes please list all locations and number of employees at each location.

Any additional enrollments to follow?: YES NO

-
- ✓ If the group has current dental coverage, please provide copy of most current dental invoice from prior carrier.

 - ✓ If the group has current dental coverage, are there any employees on COBRA?: YES NO

If yes, provide an application for each employee to be transferred to Guardian COBRA with date of original COBRA start date.

- ✓ Does the group have a company Domestic Partnership policy that they want on this policy? YES NO

If yes, provide a copy of the company's policy.

First month's premium check needed with initial applications, made payable to Guardian.



The Guardian Life Insurance Company of America
The Guardian Insurance & Annuity Company, Inc.

GG-013499NY
Enrollment Form
For Non-Medical Coverages

- Midwest Regional Office
P.O. Box 8012
Appleton, WI 54912-8012
- Northeast Regional Office
P.O. Box 26040
Lehigh Valley, PA 18002-6040
- Bridgewater Office
P.O. Box 425
E. Bridgewater, MA
02333-0425
- Western Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Planholder Name (Company Name)		Group Plan No.	Division	Class
Planholder Street Address		City	State	Zip

MARITAL STATUS: Single Married Widowed Legally Separated Divorced

PLEASE CHECK REASON FOR COMPLETING: INITIAL APPLICATION

CHANGE: ADD DEPENDENT(S) TERMINATE A FAMILY MEMBER ADDRESS NAME DELETE COVERAGE

DATE OF CHANGE ___/___/___ **REASON FOR CHANGE** _____

GIVE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE INSURED

Name (Last, First, Middle Initial)	Sex	Birthdate	Employee's Social Security #
Employee:	<input type="checkbox"/> M <input type="checkbox"/> F		
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F		Date of Marriage / /
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F		Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No

(1) Are any dependent children adopted? Yes No If "yes", indicate name and date of placement:

(2) Have you included stepchildren? Yes No If "yes", indicate name(s):

(3) Are they dependent on you for support and maintenance? Yes No

Date of Full Time Employment	Hrs. Worked / Week	Occupation / Job Title
Employee's Street Address		City
State	Zip	Business Phone # Home Phone #

DENTAL

Employee: I elect coverage. I decline coverage. I understand if I elect coverage at a later date, late entrant penalties will apply. **
Spouse: Yes No***
Child(ren): Yes No***
 ** If declining coverage, are you covered under another dental plan? Yes No

*** If declining dependent coverage, are your dependents covered under another dental plan? Yes No

DECLINATION OF COVERAGE:

Proof of insurability does not apply to dental, but I will be considered a late entrant and my dental benefits will be limited for specific periods of time. However, I and/or my dependents will not be subject to late entrant penalties if dental coverage under another plan is being discontinued as a result of termination of another plan's coverage, loss of employment, death of spouse, divorce, or where a court has ordered coverage be provided for an eligible spouse or eligible minor child(ren), and application for this plan and documentation of the loss of other coverage is received within 31 days of the termination of such coverage.

- I hereby apply for the group benefit(s) indicated above.
- I understand I must be actively at work or my coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service.
- I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance.
- The information provided above is true and correct to the best of my knowledge.
- 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.

X SIGNATURE OF EMPLOYEE	DATE
-------------------------	------

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO GUARDIAN