GUARDIAN LIFE OF THE CARIBBEAN LIMITED
GROUP INSURANCE SALES
GROUP LIFE & HEALTH QUESTIONNAIRE

Name of Company:		Nature of Business:	
No. of years in Existence:		Website (if available):	
Address of Company:		Total No. of Employees:	
Contact Numbers:		Date (MM/DD/YY):	
Name of Plan Administrator:		Agent/Broker:	

GROUP LIFE

Benefit Type Required:

- Basic Life ☐
- A.D. & D. (Accidental Death & Dismemberment) ☐
- Critical Illness Corporate New Life:
  - −Non Accelerated (independent of Life Benefit) ☐
  - −Accelerated (reduces Life Benefit) ☐
- Voluntary Life ☐
- Spouse Coverage ☐
- Dependent Coverage ☐
- Retiree's Coverage ☐

Life Benefit Amount:

Select the relevant benefit below and ensure the salary for each employee is entered on Census form

Salary Based ☐ e.g.. 1x annual salary / 2x annual salary Factor: _____

Flat Amount ☐ e.g.. $25,000.00 / $50,000.00 Amount: _____

Additional Requests: _____

_____

GROUP HEALTH

Major Medical Benefit Required:

- OPTION 1 $ 250,000.00 ☐
- OPTION 2 $ 500,000.00 ☐
- OPTION 3 $ 1,000,000.00 ☐

Plan Type:

- NEMCare (Preferred Provider Plan) ☐
- Quantum (Reimbursement Plan) ☐

Additional Requests: _____

_____

GROUP LIFE AND HEALTH

Are employees required to contribute towards the cost of the plan? Yes ☐ No ☐

IF YES, please state the percentage (%) contributed: _____% (LIFE) _____% (HEALTH)

EXISTING OR PAST GROUP LIFE OR HEALTH PLAN IN EFFECT? Yes ☐ No ☐

IF YES, please submit the following information:-

- Name of Carrier if Plan currently exists _____
- Effective Date of Existing Plan _____
- Why is a change in Carrier being considered? _____
- Renewal Date of Existing Plan _____
- The Last three years' premiums and claims figures to date broken down by year — Please attach
- The current schedule of benefits (and rates if available) — Please attach
- Letter of Authorisation — Please attach
- Any major illnesses being treated. If Yes, please provide list of diagnosis by person — Yes ☐ No ☐
- Any persons not actively at work. If Yes, please provide list — Yes ☐ No ☐
- Are there any Disabled Lives. If Yes, please provide list — Yes ☐ No ☐
- Any pregnant employees/spouses. If Yes, please provide list — Yes ☐ No ☐
- Any large losses within the last year to date. List amounts by person and diagnosis — Yes ☐ No ☐

Minimum Group Size: Health - 5-14 Employees Life - 5-14 Employees