GUARDIAN® The Guardian Life Insurance Company of America

Form No. GG-011016

# Application For Converted Disability Income Plan

**Send this form to: National Conversion Department, P. O Box 8070, Appleton, WI 54912-8070**
**Fax number: 920-749-6219**
**Secure E-mail: national_conversions@glic.com**

To be eligible for conversion you must have been insured under this plan or the combination of this plan and your employer's prior plan for at least 12 consecutive months.

You are not eligible to convert if you either become eligible for long term disability insurance under another group plan within 31 days of the date your coverage under the group plan ends, or if you have other insurance which would result in over insurance by our standards.

**The following questions must be answered.** ***(Please Print)***

| 1. Employee Name *(Last, First, M.I.)* | 2. Sex ☐ M ☐ F | 3. D.O.B | 4. Soc. Sec.# |
|---|---|---|---|

5. Employee Address *(No. & Street, City, State, Zip)*

| 6. Planholder Name | 7. Group Plan # **G-** |
|---|---|

| 8. Date you became covered by your employer's long term disability plan | 9. Date your coverage terminated under the employer's plan |
|---|---|

10. Reason for requesting conversion:
☐ Termination of Employment ☐ Other *(explain)* ______________________________

(a) Occupation at the time your Group coverage ended ______________________________

(b) Major duties of that occupation & percentage of your work week devoted to each ______________________________

______________________________

11. Last insured monthly earnings for the group plan from which you are converting: $ ______________________________

(a) Do you now have any long term disability insurance inforce? ☐ Yes ☐ No

(b) Have you applied for, or do you intend to apply for, any other disability income insurance to replace the Guardian Group long term disability income insurance which you had? ☐ Yes ☐ No

(c) If Yes, provide the following information:

| **Insurance Carrier** | **Monthly Indemnity** | **Benefit Period sick/acc** | **Indicate if Group or Individual coverage** |
|---|---|---|---|
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Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I have read my answers to the foregoing questions. I declare that they are complete and true to the best of my knowledge and belief. I understand and agree that this application shall form a part of any converted plan issued. Guardian will rely on my written statement in this application if it issues a converted plan to me.

| Signature of Proposed Insured: | Date: |
|---|---|