GUARDIAN®

Basic Protection from Guardian

Silver Voluntary Design Package

The Package You Need From a Provider You Can Trust

Now there is an easy and affordable way to protect you and your family. Guardian's voluntary package provides the following coverage:

- $25,000 of Term Life Insurance
- $75,000 of AD&D
- $1,500 per month of Disability Income*

Term Life Insurance- Available to all full-time, active employees. Benefits include a Seatbelt and Airbag Supplement, and a Conversion feature. Benefits are reduced 35% upon attainment of age 65 and an additional 25% of the original amount upon attainment of age 70.

Accidental Death & Dismemberment- We will pay the AD&D amount above for loss of life resulting from a covered accident and a percentage of that amount for other losses such as loss of hearing or loss of limb. Benefit amounts vary based on loss.

Disability Income Protection- A $1,500 maximum monthly benefit will be paid to those employees disabled on and off the job. Payments begin after satisfying a 30 day elimination period for accidents and a 90 day elimination period for sickness related disabilities. During the first 24 months, benefits are paid to those employees disabled from their own occupation.* After benefits have been paid for 24 months, benefits will continue if the employee is deemed critically disabled. An employee is considered critically disabled if unable to perform 2 or more activities of daily living or is cognitively impaired.

How much does this cost?

Employee Age	*Weekly Premium*
18 - 39	$3.50
40 - 54	$7.00
55 +	$14.00

* The maximum benefit of $1500 per month is paid if the employee's covered salary is greater than $27,000 per year. For salaries under $27,000 per year, a monthly benefit of 66 2/3% of monthly covered salary is paid.

Important Information: We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. We pay no benefits for the insured where death or dismemberment occurs while driving an automobile legally intoxicated; while voluntarily using a non-prescription substance; through intentional self-injury; while participating in a civil disorder or committing a felony; while the member of a flight crew or a trainee in an aircraft; by declared or undeclared war or act of war or armed aggression; while a member of any armed force; or as the result of a disease or a bodily infirmity. GP-1-R-ADD et al. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces); committing a felony or taking part in any riot or other civil disorder; or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor and the employee's loss of earnings is not solely due to disability. This policy provides disability income insurance only. It does not provide "basic hospital," "basic medical," or "major medical" insurance as defined by the New York State Insurance Department. If the plan is new (not transferred): This LTD plan does not pay charges relating to a pre-existing condition. A pre-existing condition includes pregnancy and any condition for which an employee, in the six-month period prior to coverage under this plan, consults with a physician, receives treatment, or takes prescribed drugs3. Please refer to the plan documents for specific time periods. GP-1-LTD2K-1.0 et al. 1A person is ADL disabled if he or she is: (a) physically unable to perform 2 or more Activities of Daily Living (ADL) without continuous physical assistance; or (b) cognitively impaired, and requires verbal cueing to protect himself/herself or others. ADL's are bathing, dressing, toileting, transferring, continence and eating. In Missouri, the minimum is 15% of the benefit or $100, in New Jersey, the minimum benefit is $100. 12/12 is required in CO, DE, IN, LO, MD, MO, MT, ND, NY OR, SC, SD, TX, VA, WI, WV, a 3/12 pre-ex is required in FL, PA, WY.

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GUARDIAN™

• Please Print clearly and in Black or Blue ink • Please Print in Capital Letters only

ENROLLMENT/CHANGE FORM
LIFE/LONG TERM DISABILITY

Planholder Name (Company Name) | **Group Plan Number** | **Division** | **Class**

PLEASE CHECK APPROPRIATE BOX ☐ Initial Enrollment/Refusal of Coverage (Complete Sections 1, 3, 4, 6) ☐ Add Employee/Dependents (Complete Sections 1, 3, 5, 6) ☐ Drop/Refuse Coverage (Complete Sections 2, 4, 6) ☐ Information Change (Complete Section 6)

SECTION 1

☐ Add Employee ☐ Add Spouse ☐ Add Children

☐ New Hire
☐ Previously refused this coverage
☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Marriage Date ____/____/____
☐ Previously refused this coverage
☐ Loss of Other Coverage (Complete Section 5 if applicable)

☐ Newborn
☐ Previously refused this coverage
☐ Adoption Date ____/____/____
☐ Loss of Other Coverage (Complete Section 5 if applicable)

SECTION 2

(The date of withdrawal cannot be prior to the date this form is completed and signed.)

☐ Drop Employee (Complete Section 4) ☐ Drop Dependents (Complete Section 4)
☐ Termination of Employment * Last Day of Coverage ____/____/____
☐ Retirement *
*Last Day Worked ____/____/____
*Last Day of Coverage ____/____/____
☐ Other _____

SECTION 3

SELECT COVERAGE(S): Dependents cannot be enrolled for coverages refused by the employee.

☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)

☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)

☐ **Long Term Disability** (if applicable, choose one option below)
☐ Buy-Up ☐ Flex AbilityGuard $_____ up to 50% of salary

SECTION 4

REFUSE/DROP COVERAGE(S): (See Refusal on back)

☐ **Life** ☐ Employee ☐ Spouse ☐ Child(ren)

☐ **AD&D** ☐ Employee ☐ Family (includes EE, Sp, Ch)

☐ **Long Term Disability**

I have been offered the above coverages and wish to refuse/ drop enrollment for the followng reasons:

☐ Covered under another insurance plan

☐ Other _____
(additional information may be required)

SECTION 5

LOSS OF OTHER COVERAGE:

I and/or my dependents were previously covered under another group plan. Loss of coverage was due to:

Termination of Employment ____/____/____

Divorce ____/____/____

Death of Spouse ____/____/____

Term./Expiration of Coverage ____/____/____

SECTION 6

Employee Name — Add ☐ Drop ☐ Last | First | MI | Sex M F | Birth Date (MM DD YYYY) | Social Security Number

Street address | City | State | ZIP

Home Phone: ( ) -

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Are you: ☐ Actively at work ☐ Retired ☐ Other _____ (additional information may be required) Occupation/Job Title:

Number of hours worked per week: Annual Salary (nearest dollar): Date of Full Time Hire (MM DD YYYY): - -

	Add ☐ Drop ☐ Last	First	MI	Sex	Student	Birth Date (MM DD YYYY)	Social Security Number
Spouse Name	☐ ☐			M F		- -	- -
Child Name	☐ ☐			M F	Y N	- -	- -
Child Name	☐ ☐			M F	Y N	- -	- -
Child Name	☐ ☐			M F	Y N	- -	- -
Child Name	☐ ☐			M F	Y N	- -	- -

A) Have you included stepchildren? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No

B) Is this your first eligible child? ☐ Yes ☐ No If "no," please list all eligible children above.

Beneficiary Designation: (Include full proper name and relationship) Name: Relationship:

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 may be guilty of insurance fraud. The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

Signature: _____ Date (MM DD YYYY) - -