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.

2003-3528

GUARDIAN® **The Guardian Life Insurance Company of America**

# Enrollment/Change Form



The Guardian Life Insurance Company of America underwrites group term life, accidental death and dismemberment, short term disability, long term disability, critical illness, dental and vision coverages.

**Managed DentalGuard, Inc.**

Managed DentalGuard, Inc. underwrites group capitated dental coverage.

☐ Midwest Regional Office
P.O. Box 8012 Appleton, WI 54912-8012

☐ Northeast Regional Office
P.O. Box 26050, Lehigh Valley, PA 18002-6050

**Please print clearly and mark carefully.**

| Employer Name: L. J. Gonzer Associates | Group Plan Number: _____<br>Benefits Effective: _____ |
|---|---|

PLEASE CHECK APPROPRIATE BOX

☐ Initial Enrollment ☐ Add Employee/ Dependents ☐ Drop/Refuse Coverage ☐ Information Change

Class: _____ Division: _____ Subtotal Code: _____

**(Please obtain this from your Employer)**

| **About You:**<br>First, MI, Last Name: | **Social Security Number**<br>___ ___ ___ - ___ ___ - ___ ___ ___ ___ |
|---|---|
| Address/City/State/Zip: | |
| Gender: M ☐ F ☐ Date of Birth (mm-dd-yy): _____ - _____ - _____ | Phone: ( ) - |
| Email Address: | |
| Are you married or do you have a spouse? ☐ Yes ☐ No<br>Do you have children or other dependents? ☐ Yes ☐ No | Date of marriage/union: _____ - _____ - _____<br>Placement date of adopted child: _____ - __ - __ - _____ |

**About Your Job:**

Hours worked per week: _____ Job Title: _____

| Work Status:<br>☐ Active ☐ Retired ☐ Cobra/State Continuation | Date of full time hire:<br>____ - ____ - ____ | Annual Salary: $_____<br>Do not include bonus/commissions |
|---|---|---|

**About Your Family: Please include the names of the dependents you wish to enroll for coverage.** ***A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.***

| | | Gender | Date of Birth (mm-dd-yyyy) | |
|---|---|---|---|---|
| Spouse (First, MI, Last Name) | | ☐M ☐F | ____ - ____ - ____ | |
| Child/Dependent 1: | ☐ Add ☐ Drop | Gender ☐M ☐F | Date of Birth (mm-dd-yyyy) ____ - ____ - ____ | Status (check all that apply)<br>☐ Student (post high school) ☐ Disabled<br>☐ Non standard dependent<br>State of Residence: _____ |
| Child/Dependent 2: | ☐ Add ☐ Drop | Gender ☐M ☐F | Date of Birth (mm-dd-yyyy) ____ - ____ - ____ | Status (check all that apply)<br>☐ Student (post high school) ☐ Disabled<br>☐ Non standard dependent<br>State of Residence: _____ |
| Child/Dependent 3: | ☐ Add ☐ Drop | Gender ☐M ☐F | Date of Birth (mm-dd-yyyy) ____ - ____ - ____ | Status (check all that apply)<br>☐ Student (post high school) ☐ Disabled<br>☐ Non standard dependent<br>State of Residence: _____ |
| Child/Dependent 4: | ☐ Add ☐ Drop | Gender ☐M ☐F | Date of Birth (mm-dd-yyyy) ____ - ____ - ____ | Status (check all that apply)<br>☐ Student (post high school) ☐ Disabled<br>☐ Non standard dependent<br>State of Residence: _____ |

**Dental Coverage:** **You must be enrolled to cover your dependents. Check only one box.**

| | Employee Only | EE & Spouse | EE & Dependent/Child(ren) | EE, Spouse & Dependent/Child(ren) |
|---|---|---|---|---|
| Option 1 | ☐ | ☐ | ☐ | ☐ |
| Option 2 | ☐ | ☐ | ☐ | ☐ |
| Option 3 | ☐ | ☐ | ☐ | ☐ |

NOT AVAILABLE

- **If PrePaid is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit guardianlife.com for a list of providers. If you do not select a PCD, one will be assigned for you.**

Employee_____ Spouse _____ Child(ren) _____

☐ I do not want this coverage. If you do not want Dental Coverage, please mark all that apply:

- ☐ I am covered under another Dental plan.
- ☐ My spouse is covered under another Dental plan.
- ☐ My dependents are covered under another Dental plan.

**Basic Life Coverage With Accidental Death and Dismemberment (AD&D):** ***You must be enrolled to cover your dependents. Check only one box.***
***Benefit reductions apply. Please see plan administrator. Employees age 65+ Benefit reductions apply. Please see plan administrator.***

| **Policy Amount** Employee Only | Spouse | Child/Dependent | **NAME YOUR BENEFICIARIES** (primary beneficiary percentages must total 100%) |
|---|---|---|---|
| ☐ _____ | ☐ _____ ****The amount may not be more than 50%of the employee amount*** | ☐ _____ ****The amount may not be more than 10% of the employee amount.*** | **Primary Beneficiaries:** **Name** _____ % _____ Relationship to employee: _____ **Name** _____ % _____ Relationship to employee: _____ **Contingent Beneficiary:** _____ (In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.) |
| ☐ I do not want this coverage. | ☐ I do not want this coverage. | ☐ I do not want this coverage. | |

If this Basic Life policy will replace your existing life insurance coverage under your current employer, provide the amount of the previous coverage.
$ _____

**Important Notes:**

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Basic Life.

**Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D):** ***You must be enrolled to cover your dependents. Check only one box.***
***Benefit reductions apply. Please see plan administrator. Employees age 65+ Benefit reductions apply. Please see plan administrator.***

| **Policy Amount** Check one box only. | ***Add* Voluntary Life for Spouse** | ***Add* Voluntary Life for Dependent/Child(ren)** |
|---|---|---|
| ☐ _____ ☐ _____ ☐ _____<br>☐ _____* ☐ _____**<br>**Guarantee Issue Amount*<br>***Guarantee Issue Amount plus Additional Amount*<br><br>☐ I do not want this coverage. | ☐ 50% of employee's amount to maximum $_____ **** The amount may not be more than 50% of the employee amount for Voluntary Life.***<br><br>☐ I do not want this coverage. | ☐ 10% of employee's amount to maximum $10,000 ****The amount may not be more than 10% of the employee amount for Voluntary Life.***<br><br>☐ I do not want this coverage. |

**Important Notes:**

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.

**Name your beneficiaries:** (primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life, please name below.

**Primary Beneficiaries:**

**Name:** _____ %_____

Relationship to employee: _____

**Name:** _____ %_____

Relationship to employee:_____

**Contingent Beneficiary:** _____

(In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

**Long-Term Disability (LTD) Coverage :**

**Core**
*Monthly benefit*
☐ _____% of salary to a maximum of $_____
☐ I do not want this coverage.

**Buy Up**
*Monthly Benefit*
☐ _____ *% of salary to a maximum of* $_____
☐ I do not want this coverage.

**Health History:**
Complete the following question if you are enrolling for one or more of the following benefits listed below. NOTE: Additional information may be required.

**Long Term Disability Basic Life Insurance Voluntary Life Insurance**

In the last 6 months have you or any of your dependents received medical care, including treatment, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; any condition related to Acquired Immune Deficiency Disorder (AIDS) or AIDS Related Complex; or any other Chronic Condition?

☐ Yes, I have. ☐ No, I haven't. ☐ Yes, my spouse has. ☐ No, my spouse hasn't.
☐ Yes, my dependent child(ren) have. ☐ No, my child(ren) haven't.

**An Evidence of Insurability form must be completed for any person with a "Yes" answer to the question above.**

**Signature**

- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that my dependent(s) cannot be enrolled for a coverage, if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- You must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations. You must be legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of insurability. Guardian has the right to reject your request.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues, if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of Guardian coverage related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing Guardian thirty (30) day prior written notice.
- **I attest that the information provided above is true and correct to the best of my knowledge.**

**Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.**

**The laws of New York require the following statement appear.If you are not a resident of New York this statement does not apply to you: 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. (Does not apply to Life Insurance.)**

**SIGNATURE OF EMPLOYEE X** _____ **DATE** _____

The requested activity is believed eligible and is approved by the Employer.

**SIGNATURE OF EMPLOYER REPRESENTATIVE X** _____ **DATE** _____

**REPRESENTATIVE'S TITLE:** _____

Enrollment kit ## ##### ###

## Fraud Warning Statements

**The laws of several states require the following statements to appear on the enrollment form. These statements apply only to residents of the noted States.**

**Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

**Delaware, Indiana and Oklahoma:** WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**Louisiana and Texas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

**New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

**Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

**Maryland and Rhode Island:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

**Ohio:** 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 is guilty of insurance fraud.

**Pennsylvania:** 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 subjects such person to criminal and civil penalties.

## INSTRUCTIONS

**Employers -** You must complete the Policyholder and Signature sections in order for this application to be processed.
**Employees -** You must complete all sections that apply to you and your dependents including the Signature section in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, select Disabled in Section E, and attach proof of disability.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.

## CONDITIONS OF ENROLLMENT - EMPLOYEE ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Guardian, or any consumer reporting agency acting on behalf of Guardian, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Guardian has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Guardian will provide coverage in accordance with the terms of the contract for the group plan.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

Guardian

# Updated Statements of ERISA Rights

In April of 2018, new regulatory requirements pertinent to disability claims promulgated by the United States Department of Labor ("DOL") went into effect. These changes amend ERISA's claims handling regulations, 29 C.F.R. Sec. 2560.503-1. In order to reflect these regulatory changes, Guardian is amending all affected Statement of ERISA Rights contained in group policies and certificates. Guardian has also revised its claims procedures so that they are in conformity with these requirements.

The DOL's revised regulations update claim and appeal rights for both short term and long-term disability insurance, as well as other forms of coverage which are dependent on the claimant's ability to demonstrate a disability such as: 1) waiver of premium for disability provisions contained in a life insurance policy; or 2) accident plans with a disability rider. These changes apply to both fully insured plans and self-insured plans which pay benefits from a separate fund, and not from general assets.

## Select the state version applicable to your coverages and print or save the pages you need.

### PLEASE COMMUNICATE THESE CHANGES TO YOUR EMPLOYEES:

- Incorporate the current Statement of ERISA Rights into your Employees' Certificate Booklets or Summary Plan Descriptions.
- Include the current Statement of ERISA Rights in all Employee Handbooks, Benefit Guides, Leave Policies and New Employee Welcome Kits, as needed.

### QUESTIONS?

If you have any questions, please contact Guardian's Customer Response Unit by telephone at 1-800-627-4200 or by email at CRU@glic.com.

We appreciate your business, and we are here to help you and your employees.

*The information in this notice is intended as a general notice of updated Disability Claims Procedures and is not intended as legal advice. Please consult with appropriate professionals for legal, tax, and compliance advice. In the event of any conflict between our presented materials and the relevant insurance policy, the policy will control. In the event you receive a statement of ERISA rights that pertains to coverage not included with your Guardian policy, please disregard it (for example, if you receive a statement of ERISA rights for life insurance coverage which is not part of your Guardian policy).*


QTB's Swipe N Save® Debit Card makes it easy and convenient for employees to pay for mass transit and parking expenses. Our Swipe N Save® Debit Card can be used at ticket vending machines, ticket offices, parking garages and lots, mail in ride programs and online ticket purchases.

**Q**ualified **T**ransportation **B**enefits must be implemented by your employer in order for the employees to reap the tax savings. Employees cannot deduct their transportation expenses from their personal income taxes

**QTB Services, Inc** specializes in outsourced administration for **Q**ualified **T**ransportation **B**enefits Program.

**QTB Services Inc.** will administer and monitor your program pursuant to government regulations. We provide all employee informational materials.

**QTB Services, Inc.** will provide customer care for both employers and their employees.

**What Expenses Qualify?**
**Mass Transit:**
Any Transit Pass defined as any pass, token, fare-card, voucher, or similar item entitling a person to a ride on a mass transit vehicle or a commuter highway vehicle. Fare on a **Commuter Highway Vehicle** (also known as a vanpool) defined as any vehicle with 6 or more adult passengers, not including the driver, used for employment transportation. Eighty percent of all vehicle miles must reasonably be expected to be for the transportation of employees from their residences to work on trips in which at least 50 percent of the available seating is occupied by commuters (excluding the driver).

**Parking:**
Parking expenses incurred by an employee at or near their work place, or at or near an area from which employees commute to work utilizing mass transit, commuter highway vehicles or carpools. This benefit cannot be used for expenses at the employee's residence.

Employees who may be interested can contact QTB Services for more information at (516) 794-1953 or via e-mail at customercare@qtbservices.com .

You can also visit their website for more information http://www.qtbservices.com

*With Verizon Wireless, you will*

# SAVE ON MONTHLY WIRELESS BILLS.

## FOR L J GONZER ASSOCIATES INC EMPLOYEES

You may be eligible for exclusive savings from Verizon Wireless*—America's Largest 4G LTE Network. Take advantage of discounts on your monthly Calling or Data Plan, phones and accessories. Exclusively for the employees of your company. Get started today.

### Have a work email address?

1. Use your work email address to register your line for your employee discount at **verizonwireless.com/discounts**
2. Enter your work email address and select **"Check for Discounts."**
3. You will immediately receive an email. Click the **"Get Started"** button in the email to continue the registration process.
4. Click on the **"Enroll Now"** button on bottom left side of page under Existing Verizon Wireless customer. Or, go to your Company's website, find the **"Verizon Wireless"** section and click on the **"Enroll Now"** button on the bottom left side of page under Existing Wireless Customer.

### Don't have a work email address?

You can complete the registration from your handset, tablet[1] or from your computer. From your browser:

1. Go to **verizonwireless.com/renewdiscount**
2. Select the 'Validate by Paystub' option
3. Complete the 'Employment Validation Form', including your account information and employer information with the business location. Click Continue.
4. Via the 'Upload Your Paystub' screen, attach your paystub. Please black out any income or other sensitive information. Your name, company name and the date must be legible on the copy you submit. See the below upload options depending on your device:
   - Option 1 – If submitting via Handset or Tablet:
     - Press the Choose File button to open the file selection options
     - Select from Files, Gallery or take a photo via the Operating System selection
     - Once the file is selected, press Upload Photo
   - Option 2 – If submitting via a computer:
     - Select Browse to locate and select your pre-saved document
     - Once the file is selected, click Upload
5. With a successful upload, you will be directed to a 'Congratulations' screen that includes a tracking number. This tracking number allows you to check the progress of your submission.
6. Your information will be reviewed and, if approved, will appear in 1-2 billing cycles.

[1]Handset and tablet option available on devices supporting iOS 6+ or Android 4.0+

Employees Discount

**8%**

Your Discount off of your Monthly Account Access Fees. 2-yr. line term on eligible Calling Plans $34.99 or higher required.

Contact your Verizon Wireless business specialist to learn about the latest products and services.

IAN AMATO | (718) 689-2475 | IAN.AMATO@VERIZONWIRELESS.COM

*Discount only applies to lines billing at $34.99 or higher. Account name must be that of the employee. If account is not in the employees name, it can be changed at a local Verizon Wireless Retail store, or by calling Customer Care at 1-800-922-0204.

verizon

# INTRODUCING MORE

## The MORE Everything Plan For Small Business

## Available NOW!

L J Gonzer Associates Inc

You need more options. Plans that give you the opportunity to video conference more, download more crucial files, and overall, use your smartphones for what they're intended for—to keep your business connected. And with Verizon, America's Largest 4G LTE Network, you'll be able to do more in more places. Enjoy unlimited Talk, Text and Shareable data on up to 25 devices with The MORE Everything Plan for Small Business:

**Select any combination of phones and data devices, up to 25.**

| Devices | Monthly Line Access (per device) |
|---|---|
| Smartphones | $40 |
| Basic Phones | $30 |
| Jetpacks/ Netbooks Notebooks/USBs | $20 |
| Tablets | $10 |
| Connected Device | $5 |

**Apple iPhone 4s 8GB**

Your Price: $0.99
New 2yr term req'd per device
$449.99 full retail price

IAN AMATO | (718) 689-2475 | IAN.AMATO@VERIZONWIRELESS.COM

# The MORE Everything Plan For Small Business

### The MORE Everything Plan For Small Business

- ***MORE data*** – up to 2x MORE data[3]
- ***MORE storage*** – now get 4x MORE cloud storage. Save space on your device and store your files and important information with 25 GB of cloud storage per line.
- ***MORE International Messaging*** – now get unlimited messaging to anywhere in the world

## MORE INTERNATIONAL ACCESS

Call Canada and Mexico with new lower rates for as little as $0.01 per minute with our International Value Plan for just $5/month.

## AND THESE GREAT BENEFITS AS PART OF YOUR MORE EVERYTHING PLAN:

- Unlimited Talk and Text
- Shareable Data for up to 25 devices on your account
- Mobile Hotspot included on all capable devices.

Choose the amount of data to share, plus get unlimited minutes and messages for all devices on your account.

| Shared Minutes and Messages | Shared Data | Monthly Account Access | Max Devices |
|---|---|---|---|
| UNLIMITED | 250 MB[1] | $15 NEW! | 10 |
| UNLIMITED | 500 MB[2] | $30 NEW! | |
| UNLIMITED | ~~500 MB~~ 1 GB | ~~$40~~ $36.80 | |
| UNLIMITED | ~~1 GB~~ 2 GB | ~~$50~~ $46.00 | |
| UNLIMITED | ~~2 GB~~ 3 GB | ~~$60~~ $55.20 | |
| UNLIMITED | 4 GB | ~~$70~~ $64.40 | |
| UNLIMITED | 6 GB | ~~$80~~ $73.60 | |
| UNLIMITED | 8 GB | ~~$90~~ $82.80 | |
| UNLIMITED | 10 GB | ~~$100~~ $92.00 | |
| UNLIMITED | 12 GB | ~~$110~~ $101.20 | |
| UNLIMITED | 14 GB | ~~$120~~ $110.40 | |
| UNLIMITED | 16 GB | ~~$130~~ $119.60 | |
| UNLIMITED | 18 GB | ~~$140~~ $128.80 | |
| UNLIMITED | 20 GB | ~~$150~~ $138.00 | |
| UNLIMITED | 30 GB | ~~$225~~ $207.00 | 25 |
| UNLIMITED | 40 GB | ~~$300~~ $276.00 | |
| UNLIMITED | 50 GB | ~~$375~~ $345.00 | |

[1]Data overage is $15/200 MB
[2]Data overage is $15/500 MB
Data overage for plans with 1 GB or more is $15/1 GB.

IAN AMATO | (718) 689-2475 | IAN.AMATO@VERIZONWIRELESS.COM

[3]More data available on 500 MB, 1 GB and 2 GB plans