GUARDIAN®

Group Number: 00512468

KING'S COLLEGE

ALL ELIG EES WORKING 30 OR MORE HOURS PER WEEK

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

PLAN HIGHLIGHTS

- Life
- Disability

Questions? Concerns?

Helpline (888) 600-1600
Call weekdays, 7:00 AM to 8:30 PM, EST.
And refer to your plan number: 00512468

GUARDIAN®

Welcome

Dear KING'S COLLEGE Employee,

We're pleased to tell you that Guardian will be our coverage provider this year. We have chosen Guardian because of its competitive rates, excellent service reputation, and extensive plan designs.

We have worked hard to negotiate group rates that will be affordable for all employees. All coverage is paid through payroll deduction.

KING'S COLLEGE

Life Benefit Summary

Group Number: 00512468

About Your Benefits:

Your family depends on you in many ways and you've worked hard to ensure their financial security. But if something happened to you, will your family be protected? Will your loved ones be able to stay in their home, pay bills, and prepare for the future. Life insurance provides a financial benefit that your family can depend on. And getting it at work is easier, more convenient and more affordable than doing it on your own. If you have financial dependents- a spouse, children or aging parents, having life insurance is a responsible and a smart decision. Enroll today to secure their future!

What Your Benefits Cover:

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides Basic Life Coverage for all full time employees in the amount of 150% of your annual salary, to a maximum of $100,000 with a minimum amount of $10,000.	$10,000 increments to a maximum of $300,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage equal to one times the employee's life benefits.	Not available
Spouse‡ Benefit	N/A	$10,000 increments to a maximum of $300,000. See Cost Illustration page for details.
Child Benefit	N/A	Your dependent children age 14 days to 26 years. You may elect one of the following benefit options: $10,000. Subject to state limits. See Cost Illustration page for details.

	BASIC LIFE	VOLUNTARY TERM LIFE
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period**.**	Underwriting may be required, depending on amount and/or age	We Guarantee Issue coverage up to: Employee $50,000. Spouse $10,000. Dependent children $10,000. An Additional $100,000 per employee, $40,000 for a spouse can be obtained with a "No" response to the Health question (on your enrollment form). Evidence of Insurability is required if the elected amount exceeds the Guarantee Issue plus Additional amount.
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take your coverage with you if you terminate employment**.**	Yes, with age and other restrictions	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
LifeAssist℠: Provides supplemental income that is calculated based off a percentage of your Life benefit to a specified dollar amount if you are ADL disabled. Benefits are paid to the lesser of 100 months or to when waiver of premium ends.	Yes	No
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	33% at age 70, 55% at age 75, 70% at age 80	33% at age 70, 55% at age 75, 70% at age 80

Subject to coverage limits

‡ **Spouse coverage terminates at age 70.**

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00512468

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style. To help you assess your needs, you can also go to Guardian Anytime and view a video: https://www.guardiananytime.com/gafd/wps/portal/fdhome/employees/products-coverage/life

Policy Election Amount	Monthly premiums displayed. Policy Election Cost Per Age Bracket								
Employee	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$10,000	$.70	$.90	$1.20	$2.00	$3.30	$5.70	$9.10	$9.90	$17.50
$20,000	$1.40	$1.80	$2.40	$4.00	$6.60	$11.40	$18.20	$19.80	$35.00
$30,000	$2.10	$2.70	$3.60	$6.00	$9.90	$17.10	$27.30	$29.70	$52.50
$40,000	$2.80	$3.60	$4.80	$8.00	$13.20	$22.80	$36.40	$39.60	$70.00
$50,000	$3.50	$4.50	$6.00	$10.00	$16.50	$28.50	$45.50	$49.50	$87.50
$60,000	$4.20	$5.40	$7.20	$12.00	$19.80	$34.20	$54.60	$59.40	$105.00
$70,000	$4.90	$6.30	$8.40	$14.00	$23.10	$39.90	$63.70	$69.30	$122.50
$80,000	$5.60	$7.20	$9.60	$16.00	$26.40	$45.60	$72.80	$79.20	$140.00
$90,000	$6.30	$8.10	$10.80	$18.00	$29.70	$51.30	$81.90	$89.10	$157.50
$100,000	$7.00	$9.00	$12.00	$20.00	$33.00	$57.00	$91.00	$99.00	$175.00
$110,000	$7.70	$9.90	$13.20	$22.00	$36.30	$62.70	$100.10	$108.90	$192.50
$120,000	$8.40	$10.80	$14.40	$24.00	$39.60	$68.40	$109.20	$118.80	$210.00
$130,000	$9.10	$11.70	$15.60	$26.00	$42.90	$74.10	$118.30	$128.70	$227.50
$140,000	$9.80	$12.60	$16.80	$28.00	$46.20	$79.80	$127.40	$138.60	$245.00
$150,000	$10.50	$13.50	$18.00	$30.00	$49.50	$85.50	$136.50	$148.50	$262.50
$160,000	$11.20	$14.40	$19.20	$32.00	$52.80	$91.20	$145.60	$158.40	$280.00
$170,000	$11.90	$15.30	$20.40	$34.00	$56.10	$96.90	$154.70	$168.30	$297.50
$180,000	$12.60	$16.20	$21.60	$36.00	$59.40	$102.60	$163.80	$178.20	$315.00
$190,000	$13.30	$17.10	$22.80	$38.00	$62.70	$108.30	$172.90	$188.10	$332.50
$200,000	$14.00	$18.00	$24.00	$40.00	$66.00	$114.00	$182.00	$198.00	$350.00
$210,000	$14.70	$18.90	$25.20	$42.00	$69.30	$119.70	$191.10	$207.90	$367.50
$220,000	$15.40	$19.80	$26.40	$44.00	$72.60	$125.40	$200.20	$217.80	$385.00
$230,000	$16.10	$20.70	$27.60	$46.00	$75.90	$131.10	$209.30	$227.70	$402.50
$240,000	$16.80	$21.60	$28.80	$48.00	$79.20	$136.80	$218.40	$237.60	$420.00
$250,000	$17.50	$22.50	$30.00	$50.00	$82.50	$142.50	$227.50	$247.50	$437.50
$260,000	$18.20	$23.40	$31.20	$52.00	$85.80	$148.20	$236.60	$257.40	$455.00
$270,000	$18.90	$24.30	$32.40	$54.00	$89.10	$153.90	$245.70	$267.30	$472.50
$280,000	$19.60	$25.20	$33.60	$56.00	$92.40	$159.60	$254.80	$277.20	$490.00
$290,000	$20.30	$26.10	$34.80	$58.00	$95.70	$165.30	$263.90	$287.10	$507.50
$300,000	$21.00	$27.00	$36.00	$60.00	$99.00	$171.00	$273.00	$297.00	$525.00

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
Policy Election Amount									
Spouse									
$10,000	$.70	$.90	$1.20	$2.00	$3.30	$5.70	$9.10	$9.90	$17.50
$20,000	$1.40	$1.80	$2.40	$4.00	$6.60	$11.40	$18.20	$19.80	$35.00
$30,000	$2.10	$2.70	$3.60	$6.00	$9.90	$17.10	$27.30	$29.70	$52.50
$40,000	$2.80	$3.60	$4.80	$8.00	$13.20	$22.80	$36.40	$39.60	$70.00
$50,000	$3.50	$4.50	$6.00	$10.00	$16.50	$28.50	$45.50	$49.50	$87.50
$60,000	$4.20	$5.40	$7.20	$12.00	$19.80	$34.20	$54.60	$59.40	$105.00
$70,000	$4.90	$6.30	$8.40	$14.00	$23.10	$39.90	$63.70	$69.30	$122.50
$80,000	$5.60	$7.20	$9.60	$16.00	$26.40	$45.60	$72.80	$79.20	$140.00
$90,000	$6.30	$8.10	$10.80	$18.00	$29.70	$51.30	$81.90	$89.10	$157.50
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$210,000	$14.70	$18.90	$25.20	$42.00	$69.30	$119.70	$191.10	$207.90	$367.50
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$240,000	$16.80	$21.60	$28.80	$48.00	$79.20	$136.80	$218.40	$237.60	$420.00
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$280,000	$19.60	$25.20	$33.60	$56.00	$92.40	$159.60	$254.80	$277.20	$490.00
$290,000	$20.30	$26.10	$34.80	$58.00	$95.70	$165.30	$263.90	$287.10	$507.50
$300,000	$21.00	$27.00	$36.00	$60.00	$99.00	$171.00	$273.00	$297.00	$525.00

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
Policy Election Amount									
Child(ren)									
$10,000	$0.60	$0.60	$0.60	$0.60	$0.60	$0.60	$0.60	$0.60	$0.60

Refer to Guarantee Issue row on page above for Voluntary Life GI+AA amounts.

Premiums for Voluntary Life Increase in five-year increments

‡**Spouse coverage premium is based on Spouse age. Coverage for the spouse terminates at spouse's age 70.**

†Benefit reductions apply.

Manage Your Benefits:

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Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00512468

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE AND AD&D COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees 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 one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

A person is ADL-disabled if he or she is (a) physically unable to perform two or more ADLs without continuous physical assistance; or (b) cognitively impaired, and requires verbal cueing to protect himself/herself or others. ADLs are bathing, dressing, toileting, transferring, continence, and eating.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

Voluntary Life Only:

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-1-R-LB-90, GP-1-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

For AD&D: We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties er on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

WillPrep Services

Special bonus for participants in voluntary life plan

Your employer has worked with Guardian to make WillPrep Services available to eligible members with Voluntary Life plans. Keeping an up-to-date will is essential to ensuring that your assets are distributed as you intended, no matter the size of your estate. You may be avoiding creating a will because you believe you can't afford the time or legal expense. Now you can with WillPrep Services.

WillPrep Services offer support and guidance to help you properly prepare the documents necessary to preserve your family's financial security. WillPrep has a range of services including online planning documents, a resource library and access to professionals* to help with issues related to:

▪ Advanced Health Care Directives	▪ Financial Power of Attorney	▪ Wills and Living Wills
▪ Estate Taxes	▪ Guardianship and Conservatorship	▪ Resource Library
▪ Executors & Probate	▪ Healthcare Power of Attorney	▪ Trusts

For more information about WillPrep Services, go to www.ibhwillprep.com; User name: WillPrep; Password: GLIC09 or call 1-877-433-6789

*The Option of an attorney prepared will is available for a small fee.
WillPrep Services are provided by Integrated Behavioral Health, Inc., and its contractors. The Guardian Life Insurance Company of America (Guardian) does not provide any part of *WillPrep Services*. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the *WillPrep Services* at any time without notice. Legal services will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.

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Long-Term Disability Benefit Summary

Group Number: 00512468

About Your Benefits:

You probably have insurance for your car or home, but what about the source of income that pays for it? You rely on your paycheck for so many things, but what if you were suddenly unable to work due to an accident or illness? How will you put food on the table, pay your mortgage or heat your home? Disability insurance can help replace lost income and make a difficult time a little easier. Protect your most valuable asset, your paycheck-enroll today!

What Your Benefits Cover:

	Long-Term Disability
Coverage amount	60% of salary to maximum $6000/month
Maximum payment period: Maximum length of time you can receive disability benefits.	To age 65, standard ADEA
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 181
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 181
COLA (Cost of Living Adjustment): Increases your net monthly benefit annually by a specified percent.	Monthly benefit increase of 3% (fixed). Unlimited adjustments.
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $6000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after exclusion
Survivor benefit: Additional benefit payable to your family if you die while disabled.	3 months

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

- **Disability (long-term):** For first two years of disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.

- **Earnings definition:** Your covered salary excludes bonuses and commissions.
- **Special limitations:** Provides a 24-month benefit limit for mental health and substance abuse.
- **Work incentive:** Plan benefit will not be reduced for a specified amount of months so that you have part-time earnings while you remain disabled, unless the combined benefit and earnings exceed 100% of your previous earnings.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00512468

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees 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 one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Long-Term Disability coverage, we pay no benefits for a disability caused or contributed to by a pre-existing condition unless the disability starts after you have been insured under this plan for a specified period of time. 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 for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. 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 during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, 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 "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA.

Contract # GP-1-LTD-15-1.0 et al.

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

BENEFITS OFFSET NOTICE

Your Guardian Group Disability Policy (Policy) may provide that any Guardian Disability benefits you receive may be offset by Other Income/ Benefits you or your dependents receive while you are receiving Guardian Disability Benefits. This means that Guardian may deduct the amount of any Other/Income Benefit payments made to you or your dependents from your weekly or monthly Guardian Disability Benefit prior to issuing payment. Examples of Other Income Benefits described in your Policy include:

- U.S. Social Security Disability Income or Retirement Benefits
- Disability or Retirement Benefits payable from any other source, including state mandated disability plans, U.S. Railroad Retirement plan or similar U.S./Canadian plan
- Salary earned or paid during your disability period, including sick leave, paid time off, severance payments, bonuses and commissions
- Workers' Compensation benefits
- No-fault motor vehicle coverage benefits
- Distributions, profit sharing, royalties

Upon enrollment, please review your certificate booklet for the full definition of Other Income Benefits and provisions pertaining benefit offsets and overpayment recovery. If you or your dependents are awarded any Other Income Benefits, including lump sum payments while you are receiving Guardian Disability benefits, you should contact Guardian promptly to calculate the appropriate offset amount and prevent an overpayment of benefits.

ADDITIONAL MATERIALS

WorkLifeMatters

Your Confidential Employee Assistance Program – Helping find balance between work and home life.

WorkLifeMatters provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

- **Unlimited free telephonic consultation with an EAP counselor available 24/7 at 800-386-7055**
- **Referrals to local counselors — up to three sessions free of charge**
- **State-of-the-art website featuring over 3,400 helpful articles on topics like wellness, training courses, and a legal and financial center**

WorkLifeMatters can offer help with:

Education
- Admissions testing & procedures
- Adult re-entry programs
- College Planning
- Financial aid resources
- Finding a pre-school

Dependent Care & Care Giving
- Adoption Assistance
- Before/after school programs
- Day Care/Elder Care
- Elder care
- In-home services

Legal and financial
- Basic tax planning
- Credit & collections
- Debt Counseling
- Home buying
- Immigration

Lifestyle & Fitness Management
- Anxiety & depression
- Divorce & separation
- Drugs & alcohol

Working Smarter
- Career development
- Effective managing
- Relocation

For more information about WorkLifeMatters, go to www.ibhworklife.com; User Name: Matters; Password: wlm70101

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GUARDIAN®

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: **KING'S COLLEGE**	Group Plan Number: **00512468**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Re-Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change ❑ Increase Amount ❑ Family Status Change

Class: ALL ELIG EES WORKING 30 OR MORE HOURS PER WEEK Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:

First, MI, Last Name:		Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
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 Date of marriage/union:____-____-_____
Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-_____

About Your Job:

Hours worked per week: _____ Job Title:

Work Status: ❑ Active ❑ Retired ❑ Cobra/State Continuation	Date of full time hire: _____ - _____ - _____	Annual Salary: $_____

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 dependent tax exemption. Dependent 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.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Jun 09, 2017

Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

Drop Coverage:

❑ Drop Employee ❑ Drop Dependents

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

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Basic Life

❑ Voluntary Life ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Long Term Disability

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

Basic Life Coverage with Accidental Death and Dismemberment (AD&D):

Benefit reductions apply. Please see plan administrator.

Policy Amount

Employee Only

☑ 150% of your annual salary to a maximum of $100,000

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

Primary Beneficiaries:

Name:_____ **Social Security Number:**___-___-_____%___

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Name:_____ **Social Security Number:**___-___-_____%___

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Contingent Beneficiary:_____ **Social Security Number:** ___-___-_____

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

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

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

Important Notes:

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

LIFE INSURANCE *continued*

Voluntary Term Life Coverage: **You must be enrolled to cover your dependents.** ***Benefit reductions apply. Please see plan administrator.***

Employee

Policy Amount ***Check one box only***

❑ $10,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ **$50,000***	❑ $60,000
❑ $70,000	❑ $80,000	❑ $90,000	❑ $100,000	❑ $110,000	❑ $120,000
❑ $130,000	❑ $140,000	❑ **$150,000****	❑ $160,000	❑ $170,000	❑ $180,000
❑ $190,000	❑ $200,000	❑ $210,000	❑ $220,000	❑ $230,000	❑ $240,000
❑ $250,000	❑ $260,000	❑ $270,000	❑ $280,000	❑ $290,000	❑ $300,000

*Guarantee Issue Amount. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected. **Guarantee Issue Amount plus Additional Amount. An Evidence of Insurability form must be completed if any amount above the Guarantee Issue Amount plus Additional Amount is elected. The Guarantee Issue with Additional Amount is $150,000**.

❑ I do not want this coverage

Add **Voluntary Life for Spouse**

Policy Amount

❑ **$10,000***	❑ $20,000	❑ $30,000	❑ $40,000	❑ **$50,000****	❑ $60,000
❑ $70,000	❑ $80,000	❑ $90,000	❑ $100,000	❑ $110,000	❑ $120,000
❑ $130,000	❑ $140,000	❑ $150,000	❑ $160,000	❑ $170,000	❑ $180,000
❑ $190,000	❑ $200,000	❑ $210,000	❑ $220,000	❑ $230,000	❑ $240,000
❑ $250,000	❑ $260,000	❑ $270,000	❑ $280,000	❑ $290,000	❑ $300,000

**Guarantee Issue Amount* ***Guarantee Issue Amount plus Additional Amount*

****The amount may not be more than 100% of the employee amount for Voluntary Life.***

❑ I do not want this coverage

Add **Voluntary Life for Dependent/Child(ren)**

Policy Amount

❑ **$10,000***

**Guarantee Issue Amount*

****The amount may not be more than 10% of the employee amount for Voluntary Life.***

❑ 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:_____ **Social Security Number:**___-___-____ %_____

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Name:_____ **Social Security Number:**___-___-____ %_____

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Contingent Beneficiary:_____ **Social Security Number:** ___-___-____

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

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

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Long-Term Disability (LTD) Coverage:

Monthly Benefit

☑ 60% of salary to a maximum of $6,000

Health History

Complete the following question(s) if you are enrolling for one or more of the following benefits listed below and you are electing an amount above coverage that is Guaranteed Issue. NOTE: Additional information may be required.

Voluntary Life

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; 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 dependent child(ren) haven't.

Have you tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or AIDS caused by the HIV infection or other sickness or condition derived from such infection?

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

An Evidence of Insurability form must be completed for any person with a "Yes" answer to the question(s) 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.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- 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.
- 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 each person's insurability. Guardian or its designee has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- 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 if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing 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 with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: 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** _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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, Nebraska, and Oregon: 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 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.

Kansas: 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 insurance fraud as determined by a court of law.

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.

Maine, Tennessee 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 benefits.

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

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

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

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.

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.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: 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 have violated state law.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER