Guardian®

LAFOURCHE PARISH SCHOOL BOARD
ALL OTHER ELIGIBLE EMPLOYEES
Group Number: 00554039

Customer Service (888) 600-1600
Monday to Friday | 8am to 8:30pm ET

Welcome to
Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1. Read through this information.
2. Find out more about your benefits.
3. Talk to your employer if you need help or have any questions.

Your coverage options

Life insurance	Protecting your family's financial future

This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

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Watch our video
How life insurance protects families and covers critical costs.

Life insurance

If something happens to you, life insurance can help your family reduce financial stress.

Life insurance helps protect your family's finances by providing a cash benefit if you pass away. This ensures that they'll be financially supported, and can cover important things from bills to funeral costs. With life policies, you can get affordable life insurance protection for a set period of time.

Who is it for?

Everyone's life insurance needs are different, depending on their family situation. That's why group life insurance through an employer is an easier and more affordable option than individual life insurance.

What does it cover?

Life insurance protects your loved ones by providing a benefit (which is usually tax-exempt) if you pass away.

Why should I consider it?

Life insurance is about more than just covering expenses. Depending on your circumstances, it could take your family years to recover from the loss of your income.

With a life insurance benefit, your family will have extra money to cover mortgage and rent payments, legal or medical fees, childcare, tuition, and any outstanding debts.

Guardian, its subsidiaries, agents, and employees do not provide tax, legal, or accounting advice. Consult your tax, legal, or accounting professional regarding your individual situation.

You will receive these benefits if you meet the conditions listed in the policy.

Preparing and planning

Jorge's never considered purchasing life insurance, but after being offered it through work, he decides it's a smart way to protect his family.

Jorge has a mortgage, and because his wife is helping to take care of her mother, she only works part-time. In addition, his daughter is about to start college.

Jorge looks at how his family would be affected by losing him.

Average funeral cost: **$9,000**

Average mortgage debt: **$202,000**

Average cost of college: **$17,000 - $44,000**

Average household credit card debt: **$8,500**

With life insurance, Jorge can make sure that part of these costs are covered if something happens to him.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

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Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides $25,000 Basic Term Life coverage for all full time employees.	$10,000 increments to a maximum of $400,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage.	Employee, Spouse & Child(ren) coverage. Maximum 1 times life amount.
Spouse Benefit	N/A	$5,000 increments to a maximum of $400,000. See Cost Illustration page for details.
Child Benefit	N/A	Your dependent children age birth† to 26 years. You may elect one of the following benefit options: $10,000. Subject to state limits. See Cost Illustration page for details.
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.	Guarantee Issue coverage up to $25,000 per employee	We Guarantee Issue coverage up to: Employee $100,000. Spouse $25,000. Dependent children $10,000.
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 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

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Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
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
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 50% at age 70, 65% at age 75	35% at age 65, 50% at age 70, 65% at age 75

Subject to coverage limits

† Voluntary Life: Infant coverage is limited based on age.

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.

	Policy Election Amount	Monthly premiums displayed. Cost of AD&D is included.
Employee	$10,000	$4.20
	$20,000	$8.40
	$30,000	$12.60
	$40,000	$16.80
	$50,000	$21.00
	$60,000	$25.20
	$70,000	$29.40
	$80,000	$33.60
	$90,000	$37.80
	$100,000	$42.00
	$110,000	$46.20
	$120,000	$50.40
	$130,000	$54.60
	$140,000	$58.80
	$150,000	$63.00
	$160,000	$67.20
	$170,000	$71.40
	$180,000	$75.60
	$190,000	$79.80
	$200,000	$84.00
	$210,000	$88.20
	$220,000	$92.40
	$230,000	$96.60
	$240,000	$100.80
	$250,000	$105.00
	$260,000	$109.20
	$270,000	$113.40
	$280,000	$117.60
	$290,000	$121.80

Voluntary Life Cost Illustration *continued*

	$300,000	$126.00
	$310,000	$130.20
	$320,000	$134.40
	$330,000	$138.60
	$340,000	$142.80
	$350,000	$147.00
	$360,000	$151.20
	$370,000	$155.40
	$380,000	$159.60
	$390,000	$163.80
	$400,000	$168.00
	Policy Election Amount	
Spouse	$5,000	$2.10
	$10,000	$4.20
	$15,000	$6.30
	$20,000	$8.40
	$25,000	$10.50
	$30,000	$12.60
	$35,000	$14.70
	$40,000	$16.80
	$45,000	$18.90
	$50,000	$21.00
	$55,000	$23.10
	$60,000	$25.20
	$65,000	$27.30
	$70,000	$29.40
	$75,000	$31.50
	$80,000	$33.60
	$85,000	$35.70
	$90,000	$37.80
	$95,000	$39.90
	$100,000	$42.00
	$105,000	$44.10
	$110,000	$46.20
	$115,000	$48.30

Voluntary Life Cost Illustration *continued*

	$120,000	$50.40
	$125,000	$52.50
	$130,000	$54.60
	$135,000	$56.70
	$140,000	$58.80
	$145,000	$60.90
	$150,000	$63.00
	$155,000	$65.10
	$160,000	$67.20
	$165,000	$69.30
	$170,000	$71.40
	$175,000	$73.50
	$180,000	$75.60
	$185,000	$77.70
	$190,000	$79.80
	$195,000	$81.90
	$200,000	$84.00
	$205,000	$86.10
	$210,000	$88.20
	$215,000	$90.30
	$220,000	$92.40
	$225,000	$94.50
	$230,000	$96.60
	$235,000	$98.70
	$240,000	$100.80
	$245,000	$102.90
	$400,000	$168.00
	Policy Election Amount	
Child(ren)	$10,000	$0.60

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.
Infant coverage is limited for the first two weeks of infant's life.
†Benefit reductions apply.

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.

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 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.

Guardian

WillPrep

Protect the ones you love with a range of dedicated services designed to help you provide for your family.

WillPrep Services includes a range of different resources that make it easier for you to prepare a will.

These range from a library of online planning documents to accessing experienced professionals that can help you with the more complicated details.

How it can help

Access simple documents including wills and power of attorney letters

Speak with consultants to discuss estate planning

Prepare your will with the assistance or support of an attorney

How to access

To access WillPrep Services, you'll need a few personal details.

Visit
willprep.uprisehealth.com

Username
WillPrep

Password
GLIC09

For more information or support, you can reach out by phoning **1 877 433 6789**.

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

WillPrep Services are provided by Uprise Health, and its contractors. The Guardian Life Insurance Company of America (Guardian) does not provide any part of Will Prep 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 Uprise Health 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, Uprise Health, or your employer.

2020-104979 (07/22)

Guardian®

Electronic Evidence of Insurability (EOI)

Our online EOI forms are an easier, quicker alternative to traditional paper forms, helping you get covered when you need to provide additional information.

There are a few situations where you need to answer health questions, enroll for higher amounts of coverage, or request coverage after the initial eligibility period. In all of these situations, our online EOI form keeps things simple.

Electronic EOI keeps things simple

With Guardian's electronic EOI forms, your data is kept secure at every stage of the process. And with fewer errors than hand-written forms, and faster submission digitally, it's easier than ever to complete it and get covered.

Electronic EOI can be used for*:

- Basic life
- Voluntary life
- Short term disability
- Long term disability

How it works

You will receive a letter or email from your employer or Guardian with instructions and a unique link to submit your EOI form online.

First register and create an account on Guardian Anytime. Then simply fill out the form, electronically sign it, and click 'Submit'.

Once we receive the form, we'll contact you with any questions, before notifying you (and your employer if the coverage amount changes).

*Applicable to coverage requiring full Evidence of Insurability (not applicable to conditional issue amounts). Electronic EOI is available using most internet browsers.

2020-109652 (10/22)

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Guardian®

Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

Important information

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.
Visit **https://www.guardiananytime.com/notice48** to read more.

No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.
Visit **https://www.guardiananytime.com/notice46** to read more.

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

Please print clearly and mark carefully.

Employer Name: **LAFOURCHE PARISH SCHOOL BOARD**	Group Plan Number: **00554039**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX Initial Enrollment Add Employee/Dependents Drop/Refuse Coverage Information Change

Class: ALL OTHER ELIGIBLE EMPLOYEES Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:

First, MI, Last Name:

Employer Provided Identification:

_____

Social Security Number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.

Address	City	State	Zip

Gender: M F Date of Birth (mm-dd-yy): ____ - ____ - ____

Phone (indicate primary): Home (____) ____ - ____
Work (____) ____ - ____
Mobile (____) ____ - ____

Email Address (indicate primary) Home _____ Work _____

Are you married or do you have a partner? Yes No Date of marriage/union:____-____-_____
Do you have children or other dependents? Yes No Placement date of adopted child: ____-____-_____

About Your Job: Job Title:

Work Status: Active Retired Cobra/State Continuation Hours worked per week: _____	Date of full time hire: _____ - _____ - _____	Annual Salary: $_____

About Your Family: **Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Your dependent's Social Security Number must be provided if enrolling for Life Coverage. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.**

Spouse (wherever the term "Spouse" appears on this form, it also includes "Partner").		Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 2:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 3:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 4:	Add Drop	Gender M F	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: Aug 18, 2022

Drop Coverage:	**Coverage Being Dropped:**
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: _____-_____-_____	Basic Life Voluntary Life Employee Spouse Child(ren)

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)

Guardian Group Plan Number: **00554039** Please print employee name:

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

Benefit reductions apply. Please see plan administrator.

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

Policy Amount
Employee Only
☑ $25,000
The Guarantee Issue Amount is $25,000.

* If Employee is 65+ benefit reductions may apply which may change the GI amount. Please see enrollment materials for details.

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

If additional space is needed, please attach a separate sheet of paper with this infformation along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records.

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.)

Please contact your employer for any record of or changes to your 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.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. Yes No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ **Social Security Number (or FEIN/TIN # if a corporate entity):** ____ ____ ____ ____ ____-____ _____ ____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____

Address/City/State/Zip: _____

Phone: ( ) -

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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

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

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

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
$310,000	$320,000	$330,000	$340,000	$350,000	$360,000
$370,000	$380,000	$390,000	$400,000		

*Guarantee Issue Amount. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

I do not want this coverage

Add **Voluntary Life for Spouse**

Policy Amount

$5,000	$10,000	$15,000	$20,000	**$25,000***	$30,000
$35,000	$40,000	$45,000	$50,000	$55,000	$60,000
$65,000	$70,000	$75,000	$80,000	$85,000	$90,000
$95,000	$100,000	$105,000	$110,000	$115,000	$120,000
$125,000	$130,000	$135,000	$140,000	$145,000	$150,000
$155,000	$160,000	$165,000	$170,000	$175,000	$180,000
$185,000	$190,000	$195,000	$200,000	$205,000	$210,000
$215,000	$220,000	$225,000	$230,000	$235,000	$240,000
$245,000	$400,000				

$_____

**Guarantee Issue Amount*

****The amount may not be more than 50% 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.**

LIFE INSURANCE *continued*

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.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

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.

Please contact your employer for any record of or changes to your beneficiary information.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. Yes No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ **Social Security Number (or FEIN/TIN # if a corporate entity):** ____ ____ ____ ____ ____-____ ____ ____
Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____
Phone: ( ) -

Signature

I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

LIFE ONLY: 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.

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.

I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.

I understand that my coverage will not be effective until approved by Guardian or its designated 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 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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

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.

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 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.

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.

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: 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: 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 : 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.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits subject to the conditions/provisions of the policy.

Oregon: 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, may be committing a fraudulent act, and may be subject to civil penalties or dental of insurance benefits.

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 OF 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.

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.

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.

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.

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.

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.

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