



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



Dental insurance

Taking care of teeth and overall health



Vision insurance

Looking after your eyesight and related health issues



Life insurance

Protecting your family's financial future



Disability insurance

Coverage if you're temporarily unable to work



Accident insurance

Helping you cover expenses after an accident

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Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

Why should I consider it?

Poor oral health isn't just aesthetic, it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.



Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

Cardiovascular disease: Some research suggests that heart disease, clogged arteries, and strokes may be linked to inflammation and infections from oral bacteria.

Osteoporosis: Weak and brittle bones may be linked to tooth loss.

Diabetes: Research shows that people with gum disease find it more difficult to control their blood sugar levels.

Alzheimer's disease: Worsening oral health is seen as Alzheimer's disease progresses.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2021.

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



Your dental coverage

Option 1 or 2: LOW or HIGH plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	Option 1: LOW		Option 2: HIGH	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Your Semi-monthly premium	\$15.33		\$19.44	
You, Spouse and Child(ren)	\$41.54		\$55.08	
Plan year deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$50	\$50	\$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	100%	100%	100%
Basic Care	80%	50%	80%	80%
Major Care	50%	50%	50%	50%
Orthodontia	Not Covered (applies to all levels)		50%	50%
Annual Maximum Benefit	\$750		\$1000	
Maximum Rollover	Yes		Yes	
Rollover Threshold	\$300		\$500	
Rollover Amount	\$150		\$250	
Rollover In-network Amount	\$200		\$350	
Rollover Account Limit	\$500		\$1000	
Lifetime Orthodontia Maximum	Not Applicable		\$1000	
Dependent Age Limits	26		26	



Your dental coverage

A Sample of Services Covered by Your Plan:

		Option 1: LOW		Option 2: HIGH	
		<i>Plan pays (on average)</i>		<i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	2 in 12 Months		2 in 12 Months	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 14		Under Age 14	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	80%	50%	80%	80%
	Fillings‡	80%	50%	80%	80%
	Perio Surgery	80%	50%	80%	80%
	Periodontal Maintenance	80%	50%	80%	80%
	Frequency:	Once Every 3 Months		Once Every 3 Months	
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	50%	80%	80%
	Root Canal	80%	50%	80%	80%
	Scaling & Root Planing (per quadrant)	80%	50%	80%	80%
	Simple Extractions	80%	50%	80%	80%
Surgical Extractions	80%	50%	80%	80%	
Major Care	Bridges and Dentures	50%	50%	50%	50%
	Dental Implants	50%	50%	50%	50%
	Inlays, Onlays, Veneers**	50%	50%	50%	50%
	Single Crowns	50%	50%	50%	50%
Orthodontia	Orthodontia	Not Covered		50%	50%
	Limits:			Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.



Your dental coverage

Manage Your Benefits:

Go to www.Guardianlife.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

Find A Dentist:

Visit www.Guardianlife.com
Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

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: 00463521

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date. Please note, self-serve options over the phone or online at Guardian Anytime are not available until the case is fully implemented, please wait to speak to a live agent when calling the Guardian Helpline.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

DentalGuard Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides DENTAL insurance only.
Policy Form # GP-1-DG2000, et al, GP-1-DEN-16

Oral Health Rewards Program

Regular visits to the dentist can help prevent and detect the early signs of serious diseases.

That's why Guardian's Maximum Rollover Oral Health Rewards Program encourages and rewards members who visit the dentist, by rolling over part of your unused annual maximum into a Maximum Rollover Account (MRA). This can be used in future years if your plan's annual maximum is reached.

How maximum rollover works*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	In-network only rollover amount	Maximum rollover account limit
\$750 Maximum claims reimbursement	\$300 Claims amount that determines rollover eligibility	\$150 Additional dollars added to a plan's annual maximum for future years	\$200 Additional dollars added if only in-network providers were used during the benefit year	\$500 The limit that cannot be exceeded within the maximum rollover account



Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

* This example has been created for illustrative purposes only.

** If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, (\$1500 PPO/\$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan. May not be available in all states.

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How maximum rollover works*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	In-network only rollover amount	Maximum rollover account limit
\$1,000 Maximum claims reimbursement	\$500 Claims amount that determines rollover eligibility	\$250 Additional dollars added to a plan's annual maximum for future years	\$350 Additional dollars added if only in-network providers were used during the benefit year	\$1,000 The limit that cannot be exceeded within the maximum rollover account



Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

* This example has been created for illustrative purposes only.

** If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, (\$1500 PPO/\$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan. May not be available in all states.

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Vision insurance

Vision insurance helps protect the health of your eyes by providing coverage for benefits that often aren't covered by regular medical insurance.

Protecting your eyesight means allowing for routine visits to the optometrist for eye exams, as well as coverage for glasses and contacts. Make sure your eyes remain in great shape at any age – no matter how much time you spend staring at digital screens.

Who is it for?

Even if you have perfect eyesight, it's important to have regular eye exams to make sure you're still seeing clearly. Most of us may eventually need vision correction, which is why we offer vision insurance to cover some of the costs.

What does it cover?

Vision insurance covers benefits not typically included in medical insurance plans. It covers things like routine eye exams, allowances towards the purchase of eyeglasses and contact lenses, as well as discounts on corrective Lasik surgery.

Why should I consider it?

Regular eye exams can detect more than failing eyesight, they can also pick up diseases like glaucoma and diabetes. Vision problems are one of the most prevalent disabilities in the United States, making vision insurance especially useful for anyone who regularly needs to purchase eyeglasses or contacts, or anyone who simply wants to help protect their eyesight and general health.

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



20/20 coverage

David notices that his vision is deteriorating. He goes in for an eye exam, and is diagnosed with myopia, which means he needs glasses.

Average cost of vision exam: **\$171**

Average cost of frames and lenses: **\$350**

Total cost: **\$521**

With a Vision policy from Guardian, David pays just **\$10** for his eye exam. After **\$25** in copay, his lenses are fully covered, and he pays **\$96** for his frames.

David's total out-of-pocket expense is **\$131**, saving him **\$390**.

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.



Your vision coverage

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of VSP's network locations, including one of the largest private practice provider networks, Visionworks and contracted Pearle Vision locations.

Your Vision Plan	Full Feature	
Your Network is	VSP Choice Network	
Copay		
Exams Copay	\$ 10	
Materials Copay <i>(waived for elective contact lenses)</i>	\$ 25	
Sample of Covered Services	<i>You pay (after copay if applicable):</i>	
	<i>In-network</i>	<i>Out-of-network</i>
Eye Exams	\$0	Amount over \$39
Single Vision Lenses	\$0	Amount over \$23
Lined Bifocal Lenses	\$0	Amount over \$37
Lined Trifocal Lenses	\$0	Amount over \$49
Lenticular Lenses	\$0	Amount over \$64
Frames	80% of amount over \$130 ¹	Amount over \$46
Costco, Walmart and Sam's Club Frame Allowance	Amount over \$70	
Contact Lenses <i>(Elective)</i>	Amount over \$130	Amount over \$100
Contact Lenses <i>(Medically Necessary)</i>	\$0	Amount over \$210
Contact Lenses <i>(Evaluation and fitting)</i>	Up to \$60	Not Applicable
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses <i>(Additional pair of frames and lenses)</i>	20% off retail price**	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses <i>(for glasses or contact lenses)</i> ‡‡	Every calendar year	
Frames	Every calendar year	
Network discounts <i>(glasses and contact lens professional service)</i>	Limitless within 12 months of exam.	
Dependent Age Limits	26	
To Find a Provider:	Register at VSP.com to find a participating provider.	

VSP

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.
- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.
- ¹Extra \$20 on select brands



Your vision coverage

- Members can use their in network benefits on line at Eyeconic.com.
- In Network Routine Retinal Screening Covered after no more than a \$39 copay.

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-I-VSN-96-VIS et al.

Laser Correction Surgery:

Discounts on average of 10-20% off usual and customary charge or 5% off promotional price for vision laser Surgery. Members out-of-pocket costs are limited to \$1,800 per eye for LASIK or \$1,500 per eye for PRK or \$2300 per eye for Custom LASIK, Custom PRK, or Bladeless LASIK.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

Guardian's Vision Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides vision care limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage. Policy Form # GP-I-GVSN-17

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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.



Your life coverage

	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 \$300,000.	\$10,000 increments to a maximum of \$500,000. 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 \$150,000. See Cost Illustration page for details.‡
Child Benefit	N/A	Your dependent children age 14 days to 26 years. \$1,000 increments to a maximum of \$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 \$300,000 per employee	We Guarantee Issue coverage up to: Employee Less than age 65 \$150,000, 65-69 \$50,000, 70+ \$10,000. Spouse Less than age 65 \$25,000, 65-69 \$10,000, 70+ \$0. 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



Your life coverage

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

Subject to coverage limits

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

The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

Annual Election Option allows employees to increase the amount of their life coverage without a medical exam when they re-enroll in their company's Voluntary Life plan. This option allows employees to step up to an amount of up to \$50,000, up to the Guarantee Issue amount.

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.

Employee	Semi-monthly premiums displayed. Cost of AD&D is included.								
	Policy Election Amount	Policy Election Cost Per Age Bracket							
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
\$10,000	\$.49	\$.51	\$.64	\$.84	\$ 1.26	\$ 1.98	\$ 2.98	\$ 4.45	\$ 8.42
\$20,000	\$.98	\$ 1.02	\$ 1.28	\$ 1.68	\$ 2.52	\$ 3.96	\$ 5.95	\$ 8.89	\$ 16.83
\$30,000	\$ 1.47	\$ 1.53	\$ 1.92	\$ 2.52	\$ 3.78	\$ 5.94	\$ 8.93	\$ 13.34	\$ 25.25
\$40,000	\$ 1.96	\$ 2.04	\$ 2.56	\$ 3.36	\$ 5.04	\$ 7.92	\$ 11.90	\$ 17.78	\$ 33.66
\$50,000	\$ 2.45	\$ 2.55	\$ 3.20	\$ 4.20	\$ 6.30	\$ 9.90	\$ 14.88	\$ 22.23	\$ 42.08
\$60,000	\$ 2.94	\$ 3.06	\$ 3.84	\$ 5.04	\$ 7.56	\$ 11.88	\$ 17.85	\$ 26.67	\$ 50.49
\$70,000	\$ 3.43	\$ 3.57	\$ 4.48	\$ 5.88	\$ 8.82	\$ 13.86	\$ 20.83	\$ 31.12	\$ 58.91
\$80,000	\$ 3.92	\$ 4.08	\$ 5.12	\$ 6.72	\$ 10.08	\$ 15.84	\$ 23.80	\$ 35.56	\$ 67.32
\$90,000	\$ 4.41	\$ 4.59	\$ 5.76	\$ 7.56	\$ 11.34	\$ 17.82	\$ 26.78	\$ 40.01	\$ 75.74
\$100,000	\$ 4.90	\$ 5.10	\$ 6.40	\$ 8.40	\$ 12.60	\$ 19.80	\$ 29.75	\$ 44.45	\$ 84.15
\$110,000	\$ 5.39	\$ 5.61	\$ 7.04	\$ 9.24	\$ 13.86	\$ 21.78	\$ 32.73	\$ 48.90	\$ 92.57
\$120,000	\$ 5.88	\$ 6.12	\$ 7.68	\$ 10.08	\$ 15.12	\$ 23.76	\$ 35.70	\$ 53.34	\$ 100.98
\$130,000	\$ 6.37	\$ 6.63	\$ 8.32	\$ 10.92	\$ 16.38	\$ 25.74	\$ 38.68	\$ 57.79	\$ 109.40
\$140,000	\$ 6.86	\$ 7.14	\$ 8.96	\$ 11.76	\$ 17.64	\$ 27.72	\$ 41.65	\$ 62.23	\$ 117.81
\$150,000	\$ 7.35	\$ 7.65	\$ 9.60	\$ 12.60	\$ 18.90	\$ 29.70	\$ 44.63	\$ 66.68	\$ 126.23
\$160,000	\$ 7.84	\$ 8.16	\$ 10.24	\$ 13.44	\$ 20.16	\$ 31.68	\$ 47.60	\$ 71.12	\$ 134.64
\$170,000	\$ 8.33	\$ 8.67	\$ 10.88	\$ 14.28	\$ 21.42	\$ 33.66	\$ 50.58	\$ 75.57	\$ 143.06
\$180,000	\$ 8.82	\$ 9.18	\$ 11.52	\$ 15.12	\$ 22.68	\$ 35.64	\$ 53.55	\$ 80.01	\$ 151.47
\$190,000	\$ 9.31	\$ 9.69	\$ 12.16	\$ 15.96	\$ 23.94	\$ 37.62	\$ 56.53	\$ 84.46	\$ 159.89
\$200,000	\$ 9.80	\$ 10.20	\$ 12.80	\$ 16.80	\$ 25.20	\$ 39.60	\$ 59.50	\$ 88.90	\$ 168.30
\$210,000	\$ 10.29	\$ 10.71	\$ 13.44	\$ 17.64	\$ 26.46	\$ 41.58	\$ 62.48	\$ 93.35	\$ 176.72
\$220,000	\$ 10.78	\$ 11.22	\$ 14.08	\$ 18.48	\$ 27.72	\$ 43.56	\$ 65.45	\$ 97.79	\$ 185.13
\$230,000	\$ 11.27	\$ 11.73	\$ 14.72	\$ 19.32	\$ 28.98	\$ 45.54	\$ 68.43	\$ 102.24	\$ 193.55
\$240,000	\$ 11.76	\$ 12.24	\$ 15.36	\$ 20.16	\$ 30.24	\$ 47.52	\$ 71.40	\$ 106.68	\$ 201.96
\$250,000	\$ 12.25	\$ 12.75	\$ 16.00	\$ 21.00	\$ 31.50	\$ 49.50	\$ 74.38	\$ 111.13	\$ 210.38
\$260,000	\$ 12.74	\$ 13.26	\$ 16.64	\$ 21.84	\$ 32.76	\$ 51.48	\$ 77.35	\$ 115.57	\$ 218.79
\$270,000	\$ 13.23	\$ 13.77	\$ 17.28	\$ 22.68	\$ 34.02	\$ 53.46	\$ 80.33	\$ 120.02	\$ 227.21
\$280,000	\$ 13.72	\$ 14.28	\$ 17.92	\$ 23.52	\$ 35.28	\$ 55.44	\$ 83.30	\$ 124.46	\$ 235.62
\$290,000	\$ 14.21	\$ 14.79	\$ 18.56	\$ 24.36	\$ 36.54	\$ 57.42	\$ 86.28	\$ 128.91	\$ 244.04

Voluntary Life Cost Illustration *continued*

	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
\$300,000	\$14.70	\$15.30	\$19.20	\$25.20	\$37.80	\$59.40	\$89.25	\$133.35	\$252.45
\$310,000	\$15.19	\$15.81	\$19.84	\$26.04	\$39.06	\$61.38	\$92.23	\$137.80	\$260.87
\$320,000	\$15.68	\$16.32	\$20.48	\$26.88	\$40.32	\$63.36	\$95.20	\$142.24	\$269.28
\$330,000	\$16.17	\$16.83	\$21.12	\$27.72	\$41.58	\$65.34	\$98.18	\$146.69	\$277.70
\$340,000	\$16.66	\$17.34	\$21.76	\$28.56	\$42.84	\$67.32	\$101.15	\$151.13	\$286.11
\$350,000	\$17.15	\$17.85	\$22.40	\$29.40	\$44.10	\$69.30	\$104.13	\$155.58	\$294.53
\$360,000	\$17.64	\$18.36	\$23.04	\$30.24	\$45.36	\$71.28	\$107.10	\$160.02	\$302.94
\$370,000	\$18.13	\$18.87	\$23.68	\$31.08	\$46.62	\$73.26	\$110.08	\$164.47	\$311.36
\$380,000	\$18.62	\$19.38	\$24.32	\$31.92	\$47.88	\$75.24	\$113.05	\$168.91	\$319.77
\$390,000	\$19.11	\$19.89	\$24.96	\$32.76	\$49.14	\$77.22	\$116.03	\$173.36	\$328.19
\$400,000	\$19.60	\$20.40	\$25.60	\$33.60	\$50.40	\$79.20	\$119.00	\$177.80	\$336.60
\$410,000	\$20.09	\$20.91	\$26.24	\$34.44	\$51.66	\$81.18	\$121.98	\$182.25	\$345.02
\$420,000	\$20.58	\$21.42	\$26.88	\$35.28	\$52.92	\$83.16	\$124.95	\$186.69	\$353.43
\$430,000	\$21.07	\$21.93	\$27.52	\$36.12	\$54.18	\$85.14	\$127.93	\$191.14	\$361.85
\$440,000	\$21.56	\$22.44	\$28.16	\$36.96	\$55.44	\$87.12	\$130.90	\$195.58	\$370.26
\$450,000	\$22.05	\$22.95	\$28.80	\$37.80	\$56.70	\$89.10	\$133.88	\$200.03	\$378.68
\$460,000	\$22.54	\$23.46	\$29.44	\$38.64	\$57.96	\$91.08	\$136.85	\$204.47	\$387.09
\$470,000	\$23.03	\$23.97	\$30.08	\$39.48	\$59.22	\$93.06	\$139.83	\$208.92	\$395.51
\$480,000	\$23.52	\$24.48	\$30.72	\$40.32	\$60.48	\$95.04	\$142.80	\$213.36	\$403.92
\$490,000	\$24.01	\$24.99	\$31.36	\$41.16	\$61.74	\$97.02	\$145.78	\$217.81	\$412.34
\$500,000	\$24.50	\$25.50	\$32.00	\$42.00	\$63.00	\$99.00	\$148.75	\$222.25	\$420.75
Policy Election Amount									
Spouse									
\$5,000	\$.25	\$.26	\$.32	\$.42	\$.63	\$.99	\$1.49	\$2.22	\$4.21
\$10,000	\$.49	\$.51	\$.64	\$.84	\$1.26	\$1.98	\$2.98	\$4.45	\$8.42
\$15,000	\$.74	\$.77	\$.96	\$1.26	\$1.89	\$2.97	\$4.46	\$6.67	\$12.62
\$20,000	\$.98	\$1.02	\$1.28	\$1.68	\$2.52	\$3.96	\$5.95	\$8.89	\$16.83
\$25,000	\$1.23	\$1.28	\$1.60	\$2.10	\$3.15	\$4.95	\$7.44	\$11.11	\$21.04
\$30,000	\$1.47	\$1.53	\$1.92	\$2.52	\$3.78	\$5.94	\$8.93	\$13.34	\$25.25
\$35,000	\$1.72	\$1.79	\$2.24	\$2.94	\$4.41	\$6.93	\$10.41	\$15.56	\$29.45
\$40,000	\$1.96	\$2.04	\$2.56	\$3.36	\$5.04	\$7.92	\$11.90	\$17.78	\$33.66
\$45,000	\$2.21	\$2.30	\$2.88	\$3.78	\$5.67	\$8.91	\$13.39	\$20.00	\$37.87
\$50,000	\$2.45	\$2.55	\$3.20	\$4.20	\$6.30	\$9.90	\$14.88	\$22.23	\$42.08

Voluntary Life Cost Illustration *continued*

	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
\$55,000	\$2.70	\$2.81	\$3.52	\$4.62	\$6.93	\$10.89	\$16.36	\$24.45	\$46.28
\$60,000	\$2.94	\$3.06	\$3.84	\$5.04	\$7.56	\$11.88	\$17.85	\$26.67	\$50.49
\$65,000	\$3.19	\$3.32	\$4.16	\$5.46	\$8.19	\$12.87	\$19.34	\$28.89	\$54.70
\$70,000	\$3.43	\$3.57	\$4.48	\$5.88	\$8.82	\$13.86	\$20.83	\$31.12	\$58.91
\$75,000	\$3.68	\$3.83	\$4.80	\$6.30	\$9.45	\$14.85	\$22.31	\$33.34	\$63.11
\$80,000	\$3.92	\$4.08	\$5.12	\$6.72	\$10.08	\$15.84	\$23.80	\$35.56	\$67.32
\$85,000	\$4.17	\$4.34	\$5.44	\$7.14	\$10.71	\$16.83	\$25.29	\$37.78	\$71.53
\$90,000	\$4.41	\$4.59	\$5.76	\$7.56	\$11.34	\$17.82	\$26.78	\$40.01	\$75.74
\$95,000	\$4.66	\$4.85	\$6.08	\$7.98	\$11.97	\$18.81	\$28.26	\$42.23	\$79.94
\$100,000	\$4.90	\$5.10	\$6.40	\$8.40	\$12.60	\$19.80	\$29.75	\$44.45	\$84.15
\$105,000	\$5.15	\$5.36	\$6.72	\$8.82	\$13.23	\$20.79	\$31.24	\$46.67	\$88.36
\$110,000	\$5.39	\$5.61	\$7.04	\$9.24	\$13.86	\$21.78	\$32.73	\$48.90	\$92.57
\$115,000	\$5.64	\$5.87	\$7.36	\$9.66	\$14.49	\$22.77	\$34.21	\$51.12	\$96.77
\$120,000	\$5.88	\$6.12	\$7.68	\$10.08	\$15.12	\$23.76	\$35.70	\$53.34	\$100.98
\$125,000	\$6.13	\$6.38	\$8.00	\$10.50	\$15.75	\$24.75	\$37.19	\$55.56	\$105.19
\$130,000	\$6.37	\$6.63	\$8.32	\$10.92	\$16.38	\$25.74	\$38.68	\$57.79	\$109.40
\$135,000	\$6.62	\$6.89	\$8.64	\$11.34	\$17.01	\$26.73	\$40.16	\$60.01	\$113.60
\$140,000	\$6.86	\$7.14	\$8.96	\$11.76	\$17.64	\$27.72	\$41.65	\$62.23	\$117.81
\$145,000	\$7.11	\$7.40	\$9.28	\$12.18	\$18.27	\$28.71	\$43.14	\$64.45	\$122.02
\$150,000	\$7.35	\$7.65	\$9.60	\$12.60	\$18.90	\$29.70	\$44.63	\$66.68	\$126.23
Policy Election Amount									
Child(ren)									
\$1,000	\$0.09	\$0.09	\$0.09	\$0.09	\$0.09	\$0.09	\$0.09	\$0.09	\$0.09
\$2,000	\$0.18	\$0.18	\$0.18	\$0.18	\$0.18	\$0.18	\$0.18	\$0.18	\$0.18
\$3,000	\$0.27	\$0.27	\$0.27	\$0.27	\$0.27	\$0.27	\$0.27	\$0.27	\$0.27
\$4,000	\$0.36	\$0.36	\$0.36	\$0.36	\$0.36	\$0.36	\$0.36	\$0.36	\$0.36
\$5,000	\$0.45	\$0.45	\$0.45	\$0.45	\$0.45	\$0.45	\$0.45	\$0.45	\$0.45
\$6,000	\$0.54	\$0.54	\$0.54	\$0.54	\$0.54	\$0.54	\$0.54	\$0.54	\$0.54
\$7,000	\$0.63	\$0.63	\$0.63	\$0.63	\$0.63	\$0.63	\$0.63	\$0.63	\$0.63
\$8,000	\$0.72	\$0.72	\$0.72	\$0.72	\$0.72	\$0.72	\$0.72	\$0.72	\$0.72
\$9,000	\$0.81	\$0.81	\$0.81	\$0.81	\$0.81	\$0.81	\$0.81	\$0.81	\$0.81
\$10,000	\$0.90	\$0.90	\$0.90	\$0.90	\$0.90	\$0.90	\$0.90	\$0.90	\$0.90

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

Premiums for Voluntary Life Increase in five-year increments

Spouse coverage premium is based on Employee age.

†Benefit reductions apply.

The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

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-I-R-LB-90, GP-I-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-I-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 Group Life Insurance underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.
Policy Form # GP-1-LIFE-15

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Disability insurance

Short term disability

Disability insurance covers a part of your income, so you can pay your bills if you're injured or sick and can't work.

Disability may be more common than you might realize, and people can be unable to work for all sorts of different reasons. There are times when many disabilities can be caused by illness, including common conditions like heart disease and arthritis. However, many disabilities aren't covered by workers' compensation.

Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It helps ensure that you'll receive a partial income if you're injured or too sick to work.

What does it cover?

Many disability insurance plans pay out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.

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



Partial income replacement

Mike injures his back in a bicycle accident and can't work for 13 weeks.

Unpaid time off work: **13 weeks**

Elimination period: **1 week**

After a 1-week elimination period following his accident, Mike's Guardian Short Term Disability policy kicks in and replaces **\$400** of his weekly income for the remaining **12 weeks** of his rehabilitation.

This gives him a total of **\$4,800** to cover his expenses while he's unable to work.

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.



Disability insurance

Long term disability

Disability insurance covers a part of your income, so you can pay your bills if you're injured or sick and can't work.

Disability may be more common than you might realize, and people can be unable to work for all sorts of different reasons. There are times when many disabilities can be caused by illness, including common conditions like heart disease and arthritis. However, many disabilities aren't covered by workers' compensation.

Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It helps ensure that you'll receive a partial income if you're injured or too sick to work.

What does it cover?

Many disability insurance plans pay out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.

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



Partial income replacement

Jim suffers a heart attack that leaves him unable to work for two years.

Unpaid time off work: **24 months**

Elimination period: **6 months**

After a 6 month elimination period, Jim's Guardian Long Term Disability policy kicks in and replaces **\$2,000** of his monthly income for the remaining **18 months** of his disability or illness.

This gives him a total of **\$36,000** to cover his expenses while he's unable to work.

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.



Your disability coverage

	Short-Term Disability	Long-Term Disability
Coverage amount	60% of salary to maximum \$1000/week	60% of salary to maximum \$7500/month
Maximum payment period: Maximum length of time you can receive disability benefits.	26 weeks	Social Security Normal Retirement Age
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 8	Day 181
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 8	Day 181
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required	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 \$1000 in coverage	We Guarantee Issue \$7500 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines	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.	Not Applicable	3 months look back; 12 months after limitation
Premium waived if disabled: Premium will not need to be paid when you are receiving benefits.	Yes	Yes
Survivor benefit: Additional benefit payable to your family if you die while disabled.	No	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.

Short-Term Disability Plan Cost Illustration:

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses.

Policy amounts shown based on sample salary amounts only.

	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
Your premium rate	\$0.410	\$0.500	\$0.770	\$0.680	\$0.500	\$0.450	\$0.600	\$0.740	\$0.890
	<i>Election Cost Per Age Bracket</i>								
	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
\$10,000 Annual Salary \$115 Weekly Benefit	\$2.36	\$2.88	\$4.43	\$3.91	\$2.88	\$2.59	\$3.45	\$4.26	\$5.12
\$20,000 Annual Salary \$231 Weekly Benefit	\$4.74	\$5.78	\$8.89	\$7.85	\$5.78	\$5.20	\$6.93	\$8.55	\$10.28
\$30,000 Annual Salary \$346 Weekly Benefit	\$7.09	\$8.65	\$13.32	\$11.76	\$8.65	\$7.79	\$10.38	\$12.80	\$15.40
\$40,000 Annual Salary \$462 Weekly Benefit	\$9.47	\$11.55	\$17.79	\$15.71	\$11.55	\$10.40	\$13.86	\$17.09	\$20.56
\$50,000 Annual Salary \$577 Weekly Benefit	\$11.83	\$14.43	\$22.22	\$19.62	\$14.43	\$12.98	\$17.31	\$21.35	\$25.68
\$60,000 Annual Salary \$692 Weekly Benefit	\$14.19	\$17.30	\$26.64	\$23.53	\$17.30	\$15.57	\$20.76	\$25.60	\$30.79
\$70,000 Annual Salary \$808 Weekly Benefit	\$16.56	\$20.20	\$31.11	\$27.47	\$20.20	\$18.18	\$24.24	\$29.90	\$35.96
\$80,000 Annual Salary \$923 Weekly Benefit	\$18.92	\$23.08	\$35.54	\$31.38	\$23.08	\$20.77	\$27.69	\$34.15	\$41.07
\$90,000 Annual Salary \$1,000 Weekly Benefit	\$20.50	\$25.00	\$38.50	\$34.00	\$25.00	\$22.50	\$30.00	\$37.00	\$44.50

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability may be 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 limit 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, DC PFML and WA PFML.
- Contract #.s GP-I-STD94-1.0 et al; GP-I-STD2K-1.0 et al; GP-I-STD07-1.0 et al; GP-I-STD-15-1.0 et al. Contract #.s GP-I-LTD94-A,B,C-1.0 et al.; GP-I-LTD2K-1.0 et al; GP-I-LTD07-1.0 et al; GP-I-LTD-15-1.0 et al.

Guardian's Group Short Term Disability and Long Term Disability Insurance are underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. 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 Department of Financial Services. Plan documents are the final arbiter of coverage. Policy Form #GP-1-STD07-1.0, et al, GP-1-STD-15, #GP-1-LTD07-1.0, et al, GP-1-LTD-15

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Accident insurance

Accidents happen. With accident insurance, you can help them hurt a bit less.

Accident insurance is an extra layer of protection that gives you a cash payment to help cover out-of-pocket expenses when you suffer an unexpected, qualifying accident.

Who is it for?

Nobody can predict when an accident might happen. That's why accident insurance is an important add-on policy for people who want to supplement the health and disability insurance coverage they already have individually or through an employer.

What does it cover?

Accident Insurance pays you lump sum of benefits after you suffer an accident. This could be more than 40 different circumstances, including: emergency treatment, ambulance, burns, dislocations, fractures, hospital confinement, and surgery.

Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. Accident insurance can be a simple, affordable way to help supplement and cover additional expenses your health and disability insurance may not cover, including x-rays, ambulance services, deductibles, and even things like rent or groceries.

Plus, accident insurance is portable and payments are made directly to you.

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



Added support during recovery

Amanda breaks her leg falling off her bike and needs emergency treatment.

Average non-surgical broken leg treatment expense: **\$2,500**

Average Major Medical deductible: **\$1,500**

Major Medical covers 80% of the surgical cost after the deductible is met, but Amanda's still responsible for 20%: **\$200**

Total out-of-pocket amount for Amanda (deductible + coinsurance): **\$1,700**

Amanda's Guardian Accident policy pays her a benefit of **\$1,700**, which covers all of her out-of-pocket expenses.

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.



Your accident coverage

ACCIDENT		
COVERAGE - DETAILS	Option 1: Value	Option 2: Advantage
Your Semi-monthly premium	\$3.02	\$4.28
You and Spouse	\$4.95	\$7.00
You and Child(ren)	\$5.21	\$7.25
You, Spouse and Child(ren)	\$7.14	\$9.97
Accident Coverage Type	Off Job	Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment.	Included	Included
ACCIDENTAL DEATH AND DISMEMBERMENT		
Benefit Amount(s)	Employee \$10,000 Spouse \$5,000 Child \$5,000	Employee \$25,000 Spouse \$12,500 Child \$5,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: \$10,000 & Airbags: \$15,000	Seatbelts: \$10,000 & Airbags: \$15,000
Reasonable Accommodation to Home or Vehicle	\$2,500	\$2,500
Child(ren) Age Limits	Children age birth to 26 years	Children age birth to 26 years
FEATURES		
Air Ambulance	\$750	\$1,000
Ambulance	\$150	\$200
Blood/Plasma/Platelets	\$300	\$300
Burns (2nd Degree/3rd Degree)	9 sq inches To 18 sq inches: \$0/\$2,000 18 sq inches To 35 sq inches: \$1,000/\$4,000 Over 35 sq inches: \$3,000/\$12,000	9 sq inches To 18 sq inches: \$0/\$2,000 18 sq inches To 35 sq inches: \$1,000/\$4,000 Over 35 sq inches: \$3,000/\$12,000
Burns - Skin Graft	50% of burn benefit	50% of burn benefit
Chiropractic Visits	\$25/visit, up to 6 visits	\$50/visit, up to 6 visits
Coma	\$7,500	\$10,000



Your accident coverage

FEATURES (Cont.)	Option 1: Value	Option 2: Advantage
Concussions	\$100	\$200
Diagnostic Exam (Major)	\$100	\$200
Dislocations	Schedule up to \$3,000	Schedule up to \$5,000
Doctor Follow-Up Visits	\$25, up to 6 treatments	\$50, up to 6 treatments
Emergency Dental Work	\$200/Crown, \$50/Extraction	\$300/Crown, \$75/Extraction
Emergency Room Treatment	\$150	\$200
Epidural Anesthesia Pain Management	\$100, 2 times per accident	\$100, 2 times per accident
Eye Injury	\$200	\$300
Family Care—Benefit is payable for each child attending a Child Care center while the insured is confined to a hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident.	\$20/day, up to 30 days	\$20/day, up to 30 days
Fractures	Schedule up to \$4,000	Schedule up to \$6,000
Hospital Admission	\$750	\$1,000
Hospital Confinement	\$165/day - up to 1 year	\$165/day - up to 1 year
Hospital ICU Admission	\$1,500	\$2,000
Hospital ICU Confinement	\$165/day - up to 15 days	\$165/day - up to 15 days
Initial Dr. Office/Urgent Care Facility Treatment	\$75	\$100
Joint Replacement (Hip/Knee/Shoulder)	\$1,500/\$750/\$750	\$2,500/\$1,250/\$1,250
Knee Cartilage	\$250	\$500
Laceration	Schedule up to \$300	Schedule up to \$400
Lodging - The hospital stay must be more than 50 miles from the insured's residence.	\$100/day, up to 30 days for companion hotel stay	\$125/day, up to 30 days for companion hotel stay
Medical Appliance—Wheelchair, motorized scooter, leg or back brace, cane, crutches, walker, walking boot that extends above the ankle or brace for the neck.	Schedule up to \$400	Schedule up to \$500
Outpatient Therapies	\$25/day, up to 10 days	\$35/day, up to 10 days
Prosthetic Device/Artificial Limb	1: \$250 2 or more: \$500	1: \$500 2 or more: \$1,000
Rehabilitation Unit Confinement	\$50/day, up to 15 days	\$100/day, up to 15 days
Ruptured Disc With Surgical Repair	\$250	\$500
Surgery (Cranial, Open Abdominal, Thoracic, Hernia) Max	Schedule up to \$1,000 Hernia: \$200	Schedule up to \$1,250 Hernia: \$250
Surgery (Exploratory or Arthroscopic)	\$300	\$400
Tendon/Ligament/Rotator Cuff	1: \$250 2 or more: \$500	1: \$500 2 or more: \$1,000
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	\$0.50 per mile, limited to \$400/round trip, up to 3 times per accident	\$0.50 per mile, limited to \$500/round trip, up to 3 times per accident
Traumatic Brain Injury — A nondegenerative, noncongenital Injury to the brain from an external nonbiological force, requiring Hospital Confinement for 48 hours or more and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms.	\$3,000	\$4,000



Your accident coverage

FEATURES (Cont.)	Option 1: Value	Option 2: Advantage
X - Ray	\$30	\$40

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passenger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.
- **Common Disaster** – Benefit is paid if both you & your spouse die in a covered accident or separate covered accidents within the same 24 hour period.
- **Reasonable Accommodation** – Benefit is payable if a modification is required to an insured's place of residence or vehicle due to an Accidental Dismemberment or Catastrophic loss.
- **Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF ACCIDENT LIMITATIONS AND EXCLUSIONS:

Employees must be 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.

This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.

This proposal is hedged subject to satisfactory financial evaluation.

We don't pay benefits for any Injury caused by or related to directly or indirectly: Sickness, disease, mental infirmity or medical or surgical treatment; the covered person being legally intoxicated; declared or undeclared war, act of war, or armed aggression; service in the armed forces, National Guard, or military reserves of any state or country; taking part in a riot or civil disorder; commission of, or attempt to commit a felony; intentionally self-inflicted Injury, while sane or insane; suicide or attempted suicide, while sane or insane; travel or flight in any kind of aircraft, including any aircraft owned by or for the

policyholder, except as a fare-paying passenger on a common carrier; participation in any kind of sporting activity for compensation or profit, including coaching or officiating; riding in or driving any motor-driven vehicle in a race, stunt show or speed test; participation in hang gliding, bungee jumping, sail gliding, parasailing, parakiting, ballooning, parachuting, zorbing or skydiving; an accident that occurred before the covered person is covered by this plan; injuries to a dependent child received during birth; voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a covered person by a doctor, and (2) it was used as prescribed. In the case of a non-prescription drug, this Plan does not pay for any Accident resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time. Job related or on the job injuries for the employee are excluded if Accident coverage is off job only.

Contract # GP-1-ACC-18

If Accident insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.

Guardian's Accident Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides Accident insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.
Policy Form # GP-1-AC-BEN-12, et al., GP-1-LAH-12R; GP-1-ACC-18

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

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



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).

Employee Assistance Program

We all need a little support every now and then.

Guardian's Employee Assistance Program gives you and your family members access to confidential personal support, across everything from stress management and nutrition to handling legal or financial issues.

The services available include consultations with experienced professionals, as well as access to resources and discounts designed to help you in a variety of different ways.

How it can help



Consultative services are available to provide direct support and assistance



Work/life assistance that can help you save money and balance commitments



Access legal and financial assistance and resources – including WillPrep Services

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

Legal/financial assistance and resources services are not available in the state of New York.

The Employee Assistance Program is a suite of services solely created and offered by Integrated Behavioral Health, Inc. (IBH), doing business as Uprise Health. Guardian is not responsible or liable for care or advice given by any provider or any service offering within the Employee Assistance Program. This information is for informational purposes only. It is not a contract. Only the plan service agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the Employee Assistance Program at any time without notice. Legal services provided through the Employee Assistance Program will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer. The Employee Assistance Program, or any individual service offering within the Program, is not an insurance benefit and may not be available in all states.



How to access



Visit

worklife.uprisehealth.com



Access Code

worklife



Call

1 800 386 7055

24 hour crisis help available.
Regular office hours:
Monday-Friday 6am-5pm PST.



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



NY Medical Verification Form

Form questioning if enrollees for Accident and/or Specified Disease coverage have medical insurance at the effective date and/or renewal date.

Visit <https://www.guardiananytime.com/notice54> to read more.

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.

Disability insurance



Disability Offset Notice

Offsets are provisions in your disability coverage that allow the insurer to deduct from your regular benefit other types of income you receive or are eligible to receive from other sources due to your disability.

Visit <https://www.guardiananytime.com/notice51> to read more.

Vision insurance



Guardian's HIPAA Notice of Privacy Practices

The notice describes how health information about you may be used and disclosed and how you can access this information.

Visit <https://www.guardiananytime.com/notice50> to read more.

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THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

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

Please print clearly and mark carefully.

Employer/Planholder Name: ST. BONAVENTURE UNIVERSITY Group Plan Number: 00463521 Benefits Effective: _____

PLEASE CHECK APPROPRIATE BOX [] Initial Enrollment [] Add Employee/Member Dependents/Family Members [] Drop/Refuse Coverage [] Information Change

In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children.

Class: ALL ELIGIBLE NEW YORK EMPLOYEES Division: _____ Subtotal Code: _____ (Please obtain this from your Employer/Planholder)

About You: Full Legal Name-First, MI, Last Name: _____ What is the name you go by? (optional) _____ Employer/Planholder Provided Identification: _____ Social Security Number or Taxpayer Identification Number (TIN) _____ Your Social Security Number of TIN must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.

Address _____ City _____ State _____ Zip _____

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

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

E mail Address (indicate primary) [] Home _____ [] Work _____

Are you married or in a civil union? [] Yes [] No Date of marriage/civil 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 or TIN 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 Address/City/State/Zip: _____ Phone: () - _____ Gender Identity: [] M [] F Social Security Number or TIN _____ Date of Birth (mm-dd-yyyy) _____

Child/Dependent 1: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number or TIN _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

Drop Coverage: <input type="checkbox"/> Drop Employee/Member <input type="checkbox"/> Drop Dependents/Family Members The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: _____ - _____ - _____ <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement Last Day Worked: _____ - _____ - _____ <input type="checkbox"/> Other Event: _____ Date of Event: _____ - _____ - _____	Coverage Being Dropped: <input type="checkbox"/> Dental <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Vision <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Basic Term Life <input type="checkbox"/> Voluntary Term Life <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Accident <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Short Term Disability
Loss Of Other Coverage: I and/or my dependents were previously covered under Loss of coverage was due to: <input type="checkbox"/> Termination of Employment: _____ - _____ - _____ <input type="checkbox"/> Divorce/Separation _____ - _____ - _____ <input type="checkbox"/> Death of Spouse _____ - _____ - _____ <input type="checkbox"/> Termination/Expiration of Coverage _____ - _____ - _____ Coverage Lost <input type="checkbox"/> Dental <input type="checkbox"/> Vision	I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____ (additional information may be required)

Dental Coverage: You must be enrolled to cover your dependents/family members. Check only one box.		
Your Semi-monthly Premium	Employee/Member Only	Employee/Member, Spouse & Dependent/Child(ren)
Option 1: LOW	<input type="checkbox"/> \$15.33	<input type="checkbox"/> \$41.54
Option 2: HIGH	<input type="checkbox"/> \$19.44	<input type="checkbox"/> \$55.08
<input type="checkbox"/> I do not want Dental Coverage because (Check as applicable): <input type="checkbox"/> I am covered under another Dental plan <input type="checkbox"/> My spouse is covered under another Dental plan <input type="checkbox"/> My dependents/family members are covered under another Dental plan		

Vision Coverage: You must be enrolled to cover your dependents/family members. Check only one box.

Full Feature	Employee/Member Only <input type="checkbox"/>	Employee/Member, Spouse & Dependent/Child(ren) <input type="checkbox"/>
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I do not want this Vision coverage because (Check as applicable):

- I am covered under another Vision plan
- My spouse is covered under another Vision plan
- My dependents/family members are covered under another Vision plan

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.

Policy Amount
Employee/Member Only
 150% of your annual salary to a maximum of \$300,000
The Guarantee Issue Amount is \$300,000.

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

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

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-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/Member: _____

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

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

Phone: () - _____ Relationship to Employee/Member: _____

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

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

Phone: () - _____ Relationship to Employee/Member: _____

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

Dependents/Family Members – If the intended beneficiary is to be someone other than the Employee/Member, 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 coverage will replace your existing life insurance coverage through your current Employer/Planholder, 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.

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D): You must be enrolled to cover your dependents/family members. *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.

Employee/Member

Policy Amount	<i>Check one box only</i>				
<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$60,000
<input type="checkbox"/> \$70,000	<input type="checkbox"/> \$80,000	<input type="checkbox"/> \$90,000	<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$110,000	<input type="checkbox"/> \$120,000
<input type="checkbox"/> \$130,000	<input type="checkbox"/> \$140,000	<input type="checkbox"/> \$150,000*	<input type="checkbox"/> \$160,000	<input type="checkbox"/> \$170,000	<input type="checkbox"/> \$180,000
<input type="checkbox"/> \$190,000	<input type="checkbox"/> \$200,000	<input type="checkbox"/> \$210,000	<input type="checkbox"/> \$220,000	<input type="checkbox"/> \$230,000	<input type="checkbox"/> \$240,000
<input type="checkbox"/> \$250,000	<input type="checkbox"/> \$260,000	<input type="checkbox"/> \$270,000	<input type="checkbox"/> \$280,000	<input type="checkbox"/> \$290,000	<input type="checkbox"/> \$300,000
<input type="checkbox"/> \$310,000	<input type="checkbox"/> \$320,000	<input type="checkbox"/> \$330,000	<input type="checkbox"/> \$340,000	<input type="checkbox"/> \$350,000	<input type="checkbox"/> \$360,000
<input type="checkbox"/> \$370,000	<input type="checkbox"/> \$380,000	<input type="checkbox"/> \$390,000	<input type="checkbox"/> \$400,000	<input type="checkbox"/> \$410,000	<input type="checkbox"/> \$420,000
<input type="checkbox"/> \$430,000	<input type="checkbox"/> \$440,000	<input type="checkbox"/> \$450,000	<input type="checkbox"/> \$460,000	<input type="checkbox"/> \$470,000	<input type="checkbox"/> \$480,000
<input type="checkbox"/> \$490,000	<input type="checkbox"/> \$500,000				

Guarantee Issue up to: Employee Less than age 65 \$150,000*, 65-69 \$50,000, 70+ \$10,000. 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					
<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$25,000*	<input type="checkbox"/> \$30,000
<input type="checkbox"/> \$35,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$45,000	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$55,000	<input type="checkbox"/> \$60,000
<input type="checkbox"/> \$65,000	<input type="checkbox"/> \$70,000	<input type="checkbox"/> \$75,000	<input type="checkbox"/> \$80,000	<input type="checkbox"/> \$85,000	<input type="checkbox"/> \$90,000
<input type="checkbox"/> \$95,000	<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$105,000	<input type="checkbox"/> \$110,000	<input type="checkbox"/> \$115,000	<input type="checkbox"/> \$120,000
<input type="checkbox"/> \$125,000	<input type="checkbox"/> \$130,000	<input type="checkbox"/> \$135,000	<input type="checkbox"/> \$140,000	<input type="checkbox"/> \$145,000	<input type="checkbox"/> \$150,000

Guarantee Issue up to: Spouse Less than age 65 \$25,000*, 65-69 \$10,000, 70+ \$0.

**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					
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$4,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$6,000
<input type="checkbox"/> \$7,000	<input type="checkbox"/> \$8,000	<input type="checkbox"/> \$9,000	<input type="checkbox"/> \$10,000*		

**Guarantee Issue Amount*

**The amount may not be more than 100% 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*

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term 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/Member: _____

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

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

Phone: () - _____ Relationship to Employee/Member: _____

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

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

Phone: () - _____ Relationship to Employee/Member: _____

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

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, 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: () - _____

Short-Term Disability (STD) Coverage:

The amount of STD 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.

Weekly Benefit

60% of salary to a maximum of \$1,000

I do not want this coverage.

Long-Term Disability (LTD) Coverage:

The amount of LTD 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.

Monthly Benefit

60% of salary to a maximum of \$7,500

Accident Coverage You must be enrolled to cover your family members.

Your Semi-monthly premium	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Dependent/Child(ren)	Employee/Member, Spouse & Dependent/Child(ren)
Option 1: Value	<input type="checkbox"/> \$3.02	<input type="checkbox"/> \$4.95	<input type="checkbox"/> \$5.21	<input type="checkbox"/> \$7.14

Option 2: Advantage

\$4.28

\$7.00

\$7.25

\$9.97

I do not want this coverage.

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term 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/Member: _____

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

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

Phone: () - _____ Relationship to Employee/Member: _____

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

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

Phone: () - _____ Relationship to Employee/Member: _____

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

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, 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: () - _____

Signature

- I understand that my dependents/family members 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/family member, other than a newborn child, will not take effect if that dependent/family member is confined to a hospital or other health care facility, or is home confined, or is unable to perform two or more Activities of Daily Living (ADL's).
- I understand no later than 30 days following delivery of accident-only, hospital indemnity, and/or specified disease coverage, Guardian will ask in a written request whether at least major medical insurance or at least basic hospital insurance and basic medical insurance (required underlying coverage) is in force on the effective date of coverage. If Guardian receives a written response that the required underlying coverage is not in force for an insured person on the effective date of coverage, the accident-only, hospital indemnity, and/or specified disease coverage for that insured person will be voided from its beginning with a full premium refund for such person.
- 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.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a 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.

- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I agree that my employer/planholder or my employer/planholder's designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.
- I state that the information provided above is true and correct to the best of my knowledge and belief.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. A discount is associated with the accelerated death benefits. A fee of up to \$250.00 will be required for the administrative cost of evaluating and processing Your application for this benefit.

The Policy permits the group Policyholder to change, reduce, restrict or terminate Your rights or benefits under the Policy without Your consent; and b) such change, reduction, restriction or termination may occur at a time when Your health status has changed and may affect Your ability to procure individual coverage.

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

READ YOUR CERTIFICATE CAREFULLY. CERTAIN WAR RISKS ARE NOT ASSUMED. IN CASE OF ANY DOUBT, CONTACT YOUR COMPANY FOR FURTHER EXPLANATION.

I understand that this is accident-only, hospital indemnity, and/or specified disease insurance. It does not provide coverage for sickness. This 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 my taxes. By my signature below, I affirmatively acknowledge that I have comprehensive hospital, surgical and medical health insurance. Please contact us at 1-800-541-7846 if you have questions about the benefits provided by this coverage.

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/MEMBER 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 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.

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.

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.

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.

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.