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Group Number: 00555836

# FREEDOM SENIOR MANAGEMENT, LLC

## ALL ELIGIBLE EMPLOYEES ELECTING SHORT TERM DISABILITY 25 WEEK DURATION

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

### **PLAN HIGHLIGHTS**

- Dental
- Vision
- Life
- Short Term Disability
- Critical Illness
- Accident
- Hospital Indemnity

# Welcome

Dear FREEDOM SENIOR MANAGEMENT, LLC Employee,

We are happy to have been chosen by FREEDOM SENIOR MANAGEMENT, LLC to be the provider of your employee benefits this year. For over 150 years, we have helped millions of people plan, secure and look after their families. We believe that life's unexpected surprises should be met with the support, guidance and understanding of someone who truly cares. And, we understand the power of help. It's why we go above and beyond to do what's right for you.

With Guardian® coverage you get:

- Affordable group rates
- Convenient payroll deduction
- Benefits for your unique needs

Take advantage of the benefits offered to you at work. Feel secure knowing that you have the coverage you need from a trusted provider and that it's there when you need it most.

Guardian

GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America®. Insurance products 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. Plan documents are the final arbiter of coverage.

2018-71635 (12/20)

**Dental Benefit Summary**
**Group Number:** 00555836

**A Dental insurance plan through Guardian:**

- Provides coverage for key preventive services such as regular checkups and cleanings to keep you and your family healthy
- Helps offset potentially expensive dental procedures, such as crowns and fillings
- Gives you access to one of the nation's largest dental networks so care is convenient to you
- Makes it easy to find a high quality certified network dentist by accessing guardiananytime.com or Guardian's find a provider mobile app
- Fast and easy claim payments

**About Your Benefits:**

**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        |                       |
|---|-------------------------------------|-----------------------|-----------------------|-----------------------|
| <b>Your Network is</b>                        | DentalGuard Preferred               |                       | DentalGuard Preferred |                       |
| <b>Calendar year deductible</b>               | <i>In-Network</i>                   | <i>Out-of-Network</i> | <i>In-Network</i>     | <i>Out-of-Network</i> |
| Individual                                    | \$50                                | \$100                 | \$50                  | \$100                 |
| Family limit                                  | 3 per family                        |                       | 3 per family          |                       |
| Waived for                                    | Preventive                          | Preventive            | Preventive            | Preventive            |
| <b>Charges covered for you (co-insurance)</b> | <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%                   | 90%                   | 80%                   |
| Major Care                                    | 50%                                 | 50%                   | 60%                   | 50%                   |
| Orthodontia                                   | Not Covered (applies to all levels) |                       | 50%                   | 50%                   |
| <b>Annual Maximum Benefit</b>                 | \$1250                              | \$1250                | \$1250                | \$1250                |
| <b>Lifetime Orthodontia Maximum</b>           | Not Applicable                      |                       | \$1000                |                       |
| <b>Dependent Age Limits</b>                   | 26 *                                |                       | 26 *                  |                       |

**\*Family coverage** for spouse and children if the child is dependent upon the employee for support and is: (i) living in the employee's household; or (ii) a full-time or part-time student.

## A Sample of Services Covered by Your Plan:

|                 |  | Option 1: LOW<br>Plan pays (on average) |                | Option 2: HIGH<br>Plan pays (on average) |                |
|-----------------|--|---|----------------|--|----------------|
|                 |  | In-network                              | Out-of-network | In-network                               | Out-of-network |
| Preventive Care | Cleaning (prophylaxis)                             | 100%                                    | 100%           | 100%                                     | 100%           |
|                 | Frequency:   | Once Every 6 Months                     |                | Once Every 6 Months                      |                |
|                 | Fluoride Treatments                                | 100%                                    | 100%           | 100%                                     | 100%           |
|                 | Limits:  | Under Age 19                            |                | Under Age 19                             |                |
|                 | Oral Exams   | 100%                                    | 100%           | 100%                                     | 100%           |
|                 | Sealants (per tooth)                               | 100%                                    | 100%           | 100%                                     | 100%           |
| Basic Care      | X-rays   | 100%                                    | 100%           | 100%                                     | 100%           |
|                 | Anesthesia*  | 80%                                     | 50%            | 90%                                      | 80%            |
|                 | Fillings‡  | 80%                                     | 50%            | 90%                                      | 80%            |
|                 | Repair & Maintenance of Crowns, Bridges & Dentures | 80%                                     | 50%            | 90%                                      | 80%            |
|                 | Simple Extractions                                 | 80%                                     | 50%            | 90%                                      | 80%            |
|                 | Surgical Extractions                               | 80%                                     | 50%            | 90%                                      | 80%            |
| Major Care      | Bridges and Dentures                               | 50%                                     | 50%            | 60%                                      | 50%            |
|                 | Inlays, Onlays, Veneers**                          | 50%                                     | 50%            | 60%                                      | 50%            |
|                 | Perio Surgery                                      | 50%                                     | 50%            | 60%                                      | 50%            |
|                 | Periodontal Maintenance                            | 50%                                     | 50%            | 60%                                      | 50%            |
|                 | Frequency:   | Once Every 6 Months                     |                | Once Every 6 Months                      |                |
|                 | Root Canal   | 50%                                     | 50%            | 60%                                      | 50%            |
|                 | Scaling & Root Planing (per quadrant)              | 50%                                     | 50%            | 60%                                      | 50%            |
|                 | Single Crowns                                      | 50%                                     | 50%            | 60%                                      | 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.

***This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.***

### Manage Your Benefits:

Go to [www.GuardianAnytime.com](http://www.GuardianAnytime.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.GuardianAnytime.com](http://www.GuardianAnytime.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.

## 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-I-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

**Vision Benefit Summary**
**Group Number:** 00555836

**Why choose Guardian for your Vision insurance:**

For just a few dollars a month, this coverage saves you money on optical wellness, as well as providing discounts on eyewear, contacts, and corrective vision services

- Extensive network of vision specialists and medical professionals
- Affordable coverage
- Quick and easy claim payments

**About Your Benefits:**

**Option 1:** Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of Davis Vision's network locations including retail centers such as Costco®, Wal-Mart®, JCPenney®, Sears®, Target®, Sam's Club®, Pearle®, Visionworks®, and Visionworks Online®.

| <b>Your Vision Plan</b>   |  | <b>Full Feature - Designer</b>  |
|---|--|---|
| <b>Your Network is</b>  |  | Davis Vision  |
| <b>Copay</b>  |  |   |
| Exams Copay   |  | \$ 10   |
| Materials Copay (waived for elective contact lenses)              |  | \$ 10   |
| <b>Sample of Covered Services</b>                                 |  | <i>You pay (after copay if applicable):</i>   |
|   | <i>In-network</i>  | <i>Out-of-network</i>   |
| Eye Exams   | \$0  | Amount over \$50  |
| Single Vision Lenses  | \$0  | Amount over \$48  |
| Lined Bifocal Lenses  | \$0  | Amount over \$67  |
| Lined Trifocal Lenses   | \$0  | Amount over \$86  |
| Lenticular Lenses   | \$0  | Amount over \$126   |
| Frames  | 80% of amount over \$150*2   | Amount over \$48  |
| Contact Lenses (Elective and conventional)                        | 85% of amount over \$150*  | Amount over \$105   |
| Contact Lenses (Planned replacement and disposable)               | 85% of amount over \$150*  | Amount over \$105   |
| Contact Lenses (Medically Necessary)                              | \$0  | Amount over \$210   |
| Cosmetic Extras   | Avg. 40-60% off retail price   | No discounts  |
| Glasses (Additional pair of frames and lenses)                    | Courtesy discount from most providers  | No discounts  |
| Laser Correction Surgery Discount                                 | Up to 25% off the usual charge or 5% off promotional price                                 | No discounts  |
| <b>Service Frequencies</b>  |  |   |
| Exams   | Every calendar year  |   |
| Lenses (for glasses or contact lenses)††                          | Every calendar year  |   |
| Frames  | Every two calendar years   |   |
| Network discounts (glasses and contact lens professional service) | Applies to first purchase & courtesy discount from most providers on subsequent purchases. |   |
| <b>Dependent Age Limits</b>                                       |  | 26  |
|   |  | Visit <a href="http://www.GuardianAnytime.com">www.GuardianAnytime.com</a> and click on "Find a Provider" |

*This is only a partial list of vision services. Your certificate of benefits will show exactly what is covered and excluded.*

**Davis**

- ††Benefit includes coverage for glasses or contact lenses, not both.
- Family coverage for spouse and children if the child is dependent upon the employee for support and is: (i) living in the employee's household; or (ii) a full-time or part-time student.

Benefit information illustrated within this material reflects the plan covered by Guardian as of 02/17/2020

ALL ELIGIBLE EMPLOYEES ELECTING SHORT TERM DISABILITY 25 WEEK DURATION Benefit Summary

The Guardian Life Insurance Company of America, New York, NY

- Contact lenses from Davis Vision's Collection are available at most private practice locations with Full Feature and Materials Only plans. Contacts from the collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.
- \*Due to lower prices available at Costco, Wal-mart and Sam's Club locations, some private providers may not allow discounts
- For Davis Vision, complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period. Only 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.
- <sup>2</sup>Extra \$50 at Visionworks stores and at Visionworks.com. Members can also use their in network benefits at Visionworks.com.
- Davis Vision offers 2,000 College Tuition Benefit Rewards, which are administered by SAGE CTB, LLC.

***This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.***

## Manage Your Benefits:

Go to [www.GuardianAnytime.com](http://www.GuardianAnytime.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.

## 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-DAVIS-05-VIS et al.

### Laser Correction Surgery:

Up to 25% off for vision laser surgery.

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.

# College Tuition Benefit Self-Registration

Welcome to the College Tuition Benefit Rewards program. Create your Rewards account to take advantage of Tuition Rewards® that can be used to pay up to one year's tuition at 400+ participating colleges and universities nationwide.

## How it Works

- Go to [guardian.collegetuitionbenefit.com](http://guardian.collegetuitionbenefit.com) to set up your SAGE Scholars Tuition Rewards account. Your User ID is your Guardian Group Plan Number that can be found in the card below or in your benefit booklet. Password is Guardian.
- You'll earn 2,000 Tuition Rewards every year you are enrolled in a plan that includes the College Tuition Benefit. Each Tuition Reward point equals a \$1 reduction in full tuition.
- Rewards can be given to children, stepchildren, grandchildren, nieces, nephews and Godchildren. Each student receives an additional 500 Tuition Rewards once registered. Rewards never expire and can be kept forever.

## See how rewards add up when you enroll in your Guardian plan!

| Guardian Insurance Product | Year 1       | Year 2       | Year 3       | Year 4       | Year 5       | Year 6       | Year 7       | Total         |
|----------------------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|---------------|
| <b>Davis Vision</b>        | 2,000        | 2,000        | 2,000        | 2,000        | 2,000        | 2,000        | 2,000        | <b>14,000</b> |
| <b>Total</b>               | <b>2,000</b> | <b>2,000</b> | <b>2,000</b> | <b>2,000</b> | <b>2,000</b> | <b>2,000</b> | <b>2,000</b> | <b>14,000</b> |

Guardian Davis Vision Rewards are offered by Davis Vision and are credited to your Guardian account like other Rewards. Registration is the same as other Guardian products that have CTB.


## Important Deadlines

- You must register students in your Rewards account by August 24 of the year when the student begins 11th grade.
- The last day for allocating earned Tuition Rewards to a student registered in your Rewards account is August 24 of the year the student begins 12th grade.

## Visit [guardian.collegetuitionbenefit.com](http://guardian.collegetuitionbenefit.com) to register, see a full list of participating schools and learn more.

The Tuition Rewards program is provided by SAGE CTB, LLC. Guardian does not provide any services related to this program. SAGE CTB, LLC is not a subsidiary or an affiliate of Guardian. Guardian reserves the right to discontinue the College Tuition Benefit program at any time without notice. The College Tuition Benefit (CTB) is not an insurance benefit and may not be available in all states. Group insurance coverage is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. 2019-79659 (05-21)

(Print and cut out ID Card)

|  |   |
|--|---|
| <b>College Tuition Benefits<br/>Rewards ID Card</b>  |    |
| Register @<br><a href="http://Guardian.CollegeTuitionBenefit.com">Guardian.CollegeTuitionBenefit.com</a><br><br>User ID: plan number<br><br>Password: Guardian | <b>The College Tuition Benefit</b><br><br>Phone: 215 839 0119<br>Email:<br><a href="mailto:support@collegetuitionbenefit.com">support@collegetuitionbenefit.com</a> |



## **NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**Effective: 05/01/2016**

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at [www.guardianlife.com/privacy-policy](http://www.guardianlife.com/privacy-policy).

### **What is Protected Health Information (PHI):**

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

### **In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):**

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

#### **Guardian has the right to use or disclose your PHI for the following purposes:**

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.



Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures.

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use or disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

**Your Rights with Regard to Your Protected Health Information (PHI):**

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclose your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI may require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures. An 'accounting of disclosures' is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Accounting of Disclosure requests is available at [www.guardianlife.com/privacy-policy](http://www.guardianlife.com/privacy-policy).

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications. You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

Your Right to Amend Your PHI If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

**How to Contact Us:**

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:       Guardian Corporate Privacy Officer  
National Operations

Address:        The Guardian Life Insurance Company of America  
Group Quality Assurance - Northeast  
P.O. Box 981573  
El Paso, TX 79998-1573

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**Life Benefit Summary**
**Group Number:** 00555836

**A Life insurance plan through Guardian provides:**

- The foundation of a smart financial plan that helps protect you and those who depend on you
- Affordable group rates
- Flexibility to update your coverage as your life changes or take it with you if you change jobs or retire

**About Your Benefits:**

|   | <b>BASIC LIFE</b>   | <b>VOLUNTARY TERM LIFE</b>   |
|---|---|--|
| <b>Employee Benefit</b>   | Your employer provides Basic Life Coverage for all full time employees in the amount of 100% of your annual salary, to a maximum of \$50,000 with a minimum amount of \$10,000. | \$10,000 increments to a maximum of \$500,000. See Cost Illustration page for details.   |
| <b>Accidental Death and Dismemberment</b>   | Your Basic Life coverage includes Enhanced Accidental Death and Dismemberment coverage.   | Enhanced employee, spouse, and child(ren) coverage. Maximum 1 times life amount.   |
| <b>Spouse/Domestic Partner Benefit</b>  | N/A   | \$5,000 increments to a maximum of \$100,000. See Cost Illustration page for details.  |
| <b>Child Benefit</b>  | N/A   | Your dependent children age birth† to 26 years.<br>You may elect one of the following benefit options: \$10,000. Subject to state limits. See Cost Illustration page for details.                      |
| <b>Guarantee Issue:</b> 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 \$50,000 per employee  | We Guarantee Issue coverage up to:<br>Employee Less than age 65 \$100,000, 65-69 \$50,000, 70+ \$10,000.<br>Spouse Less than age 65 \$25,000, 65-69 \$10,000, 70+ \$0.<br>Dependent children \$10,000. |
| <b>Premiums</b>   | Covered by your company if you meet eligibility requirements  | Increase on plan anniversary after you enter next five-year age group  |
| <b>Portability:</b> Allows you to take coverage with you if you terminate employment.   | Yes, with age and other restrictions  | Yes, with age and other restrictions   |
| <b>Conversion:</b> 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  |
| <b>Accelerated Life Benefit:</b> A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.  | Yes   | Yes  |

**BASIC LIFE****VOLUNTARY TERM LIFE**

|  |  |  |
|--|--|--|
| <b>Waiver of Premiums:</b> 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 |
| <b>Benefit Reductions:</b> Benefits are reduced by a certain percentage as an employee ages. | 35% at age 65, 60% at age 70, 75% at age 75  | 35% at age 65, 60% at age 70, 75% at age 75  |

Subject to coverage limits

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

**Manage Your Benefits:**

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

## Voluntary Life Cost Illustration:

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

| Policy Election Amount |  | Monthly premiums displayed. Cost of AD&D is included. |         |         |         |         |          |          |                          |
|------------------------|--|---|---------|---------|---------|---------|----------|----------|--------------------------|
| Employee               |  | Policy Election Cost Per Age Bracket                  |         |         |         |         |          |          |                          |
|                        |  | < 30  | 30-34   | 35-39   | 40-44   | 45-49   | 50-54    | 55-59    | 60-64 65-69 <sup>†</sup> |
| \$10,000               |  | \$ .80  | \$1.20  | \$1.30  | \$1.80  | \$3.00  | \$5.30   | \$8.90   | \$23.20                  |
| \$20,000               |  | \$1.60  | \$2.40  | \$2.60  | \$3.60  | \$6.00  | \$10.60  | \$17.80  | \$46.40                  |
| \$30,000               |  | \$2.40  | \$3.60  | \$3.90  | \$5.40  | \$9.00  | \$15.90  | \$26.70  | \$69.60                  |
| \$40,000               |  | \$3.20  | \$4.80  | \$5.20  | \$7.20  | \$12.00 | \$21.20  | \$35.60  | \$92.80                  |
| \$50,000               |  | \$4.00  | \$6.00  | \$6.50  | \$9.00  | \$15.00 | \$26.50  | \$44.50  | \$116.00                 |
| \$60,000               |  | \$4.80  | \$7.20  | \$7.80  | \$10.80 | \$18.00 | \$31.80  | \$53.40  | \$139.20                 |
| \$70,000               |  | \$5.60  | \$8.40  | \$9.10  | \$12.60 | \$21.00 | \$37.10  | \$62.30  | \$162.40                 |
| \$80,000               |  | \$6.40  | \$9.60  | \$10.40 | \$14.40 | \$24.00 | \$42.40  | \$71.20  | \$185.60                 |
| \$90,000               |  | \$7.20  | \$10.80 | \$11.70 | \$16.20 | \$27.00 | \$47.70  | \$80.10  | \$208.80                 |
| \$100,000              |  | \$8.00  | \$12.00 | \$13.00 | \$18.00 | \$30.00 | \$53.00  | \$89.00  | \$232.00                 |
| \$110,000              |  | \$8.80  | \$13.20 | \$14.30 | \$19.80 | \$33.00 | \$58.30  | \$97.90  | \$255.20                 |
| \$120,000              |  | \$9.60  | \$14.40 | \$15.60 | \$21.60 | \$36.00 | \$63.60  | \$106.80 | \$278.40                 |
| \$130,000              |  | \$10.40   | \$15.60 | \$16.90 | \$23.40 | \$39.00 | \$68.90  | \$115.70 | \$301.60                 |
| \$140,000              |  | \$11.20   | \$16.80 | \$18.20 | \$25.20 | \$42.00 | \$74.20  | \$124.60 | \$324.80                 |
| \$150,000              |  | \$12.00   | \$18.00 | \$19.50 | \$27.00 | \$45.00 | \$79.50  | \$133.50 | \$348.00                 |
| \$160,000              |  | \$12.80   | \$19.20 | \$20.80 | \$28.80 | \$48.00 | \$84.80  | \$142.40 | \$371.20                 |
| \$170,000              |  | \$13.60   | \$20.40 | \$22.10 | \$30.60 | \$51.00 | \$90.10  | \$151.30 | \$394.40                 |
| \$180,000              |  | \$14.40   | \$21.60 | \$23.40 | \$32.40 | \$54.00 | \$95.40  | \$160.20 | \$417.60                 |
| \$190,000              |  | \$15.20   | \$22.80 | \$24.70 | \$34.20 | \$57.00 | \$100.70 | \$169.10 | \$440.80                 |
| \$200,000              |  | \$16.00   | \$24.00 | \$26.00 | \$36.00 | \$60.00 | \$106.00 | \$178.00 | \$464.00                 |
| \$210,000              |  | \$16.80   | \$25.20 | \$27.30 | \$37.80 | \$63.00 | \$111.30 | \$186.90 | \$487.20                 |
| \$220,000              |  | \$17.60   | \$26.40 | \$28.60 | \$39.60 | \$66.00 | \$116.60 | \$195.80 | \$510.40                 |
| \$230,000              |  | \$18.40   | \$27.60 | \$29.90 | \$41.40 | \$69.00 | \$121.90 | \$204.70 | \$533.60                 |
| \$240,000              |  | \$19.20   | \$28.80 | \$31.20 | \$43.20 | \$72.00 | \$127.20 | \$213.60 | \$556.80                 |
| \$250,000              |  | \$20.00   | \$30.00 | \$32.50 | \$45.00 | \$75.00 | \$132.50 | \$222.50 | \$580.00                 |
| \$260,000              |  | \$20.80   | \$31.20 | \$33.80 | \$46.80 | \$78.00 | \$137.80 | \$231.40 | \$603.20                 |
| \$270,000              |  | \$21.60   | \$32.40 | \$35.10 | \$48.60 | \$81.00 | \$143.10 | \$240.30 | \$626.40                 |
| \$280,000              |  | \$22.40   | \$33.60 | \$36.40 | \$50.40 | \$84.00 | \$148.40 | \$249.20 | \$649.60                 |
| \$290,000              |  | \$23.20   | \$34.80 | \$37.70 | \$52.20 | \$87.00 | \$153.70 | \$258.10 | \$672.80                 |
| \$300,000              |  | \$24.00   | \$36.00 | \$39.00 | \$54.00 | \$90.00 | \$159.00 | \$267.00 | \$696.00                 |
| \$310,000              |  | \$24.80   | \$37.20 | \$40.30 | \$55.80 | \$93.00 | \$164.30 | \$275.90 | \$719.20                 |

**Voluntary Life Cost Illustration** *continued*

|                               | < 30    | 30–34   | 35–39   | 40–44   | 45–49    | 50–54    | 55–59    | 60–64    | 65–69†     |
|-------------------------------|---------|---------|---------|---------|----------|----------|----------|----------|------------|
| \$320,000                     | \$25.60 | \$38.40 | \$41.60 | \$57.60 | \$96.00  | \$169.60 | \$284.80 | \$473.60 | \$742.40   |
| \$330,000                     | \$26.40 | \$39.60 | \$42.90 | \$59.40 | \$99.00  | \$174.90 | \$293.70 | \$488.40 | \$765.60   |
| \$340,000                     | \$27.20 | \$40.80 | \$44.20 | \$61.20 | \$102.00 | \$180.20 | \$302.60 | \$503.20 | \$788.80   |
| \$350,000                     | \$28.00 | \$42.00 | \$45.50 | \$63.00 | \$105.00 | \$185.50 | \$311.50 | \$518.00 | \$812.00   |
| \$360,000                     | \$28.80 | \$43.20 | \$46.80 | \$64.80 | \$108.00 | \$190.80 | \$320.40 | \$532.80 | \$835.20   |
| \$370,000                     | \$29.60 | \$44.40 | \$48.10 | \$66.60 | \$111.00 | \$196.10 | \$329.30 | \$547.60 | \$858.40   |
| \$380,000                     | \$30.40 | \$45.60 | \$49.40 | \$68.40 | \$114.00 | \$201.40 | \$338.20 | \$562.40 | \$881.60   |
| \$390,000                     | \$31.20 | \$46.80 | \$50.70 | \$70.20 | \$117.00 | \$206.70 | \$347.10 | \$577.20 | \$904.80   |
| \$400,000                     | \$32.00 | \$48.00 | \$52.00 | \$72.00 | \$120.00 | \$212.00 | \$356.00 | \$592.00 | \$928.00   |
| \$410,000                     | \$32.80 | \$49.20 | \$53.30 | \$73.80 | \$123.00 | \$217.30 | \$364.90 | \$606.80 | \$951.20   |
| \$420,000                     | \$33.60 | \$50.40 | \$54.60 | \$75.60 | \$126.00 | \$222.60 | \$373.80 | \$621.60 | \$974.40   |
| \$430,000                     | \$34.40 | \$51.60 | \$55.90 | \$77.40 | \$129.00 | \$227.90 | \$382.70 | \$636.40 | \$997.60   |
| \$440,000                     | \$35.20 | \$52.80 | \$57.20 | \$79.20 | \$132.00 | \$233.20 | \$391.60 | \$651.20 | \$1,020.80 |
| \$450,000                     | \$36.00 | \$54.00 | \$58.50 | \$81.00 | \$135.00 | \$238.50 | \$400.50 | \$666.00 | \$1,044.00 |
| \$460,000                     | \$36.80 | \$55.20 | \$59.80 | \$82.80 | \$138.00 | \$243.80 | \$409.40 | \$680.80 | \$1,067.20 |
| \$470,000                     | \$37.60 | \$56.40 | \$61.10 | \$84.60 | \$141.00 | \$249.10 | \$418.30 | \$695.60 | \$1,090.40 |
| \$480,000                     | \$38.40 | \$57.60 | \$62.40 | \$86.40 | \$144.00 | \$254.40 | \$427.20 | \$710.40 | \$1,113.60 |
| \$490,000                     | \$39.20 | \$58.80 | \$63.70 | \$88.20 | \$147.00 | \$259.70 | \$436.10 | \$725.20 | \$1,136.80 |
| \$500,000                     | \$40.00 | \$60.00 | \$65.00 | \$90.00 | \$150.00 | \$265.00 | \$445.00 | \$740.00 | \$1,160.00 |
| <b>Policy Election Amount</b> |         |         |         |         |          |          |          |          |            |
| Spouse/DP                     |         |         |         |         |          |          |          |          |            |
| \$5,000                       | \$ .40  | \$ .60  | \$ .65  | \$ .90  | \$1.50   | \$2.65   | \$4.45   | \$7.40   | \$11.60    |
| \$10,000                      | \$ .80  | \$1.20  | \$1.30  | \$1.80  | \$3.00   | \$5.30   | \$8.90   | \$14.80  | \$23.20    |
| \$15,000                      | \$1.20  | \$1.80  | \$1.95  | \$2.70  | \$4.50   | \$7.95   | \$13.35  | \$22.20  | \$34.80    |
| \$20,000                      | \$1.60  | \$2.40  | \$2.60  | \$3.60  | \$6.00   | \$10.60  | \$17.80  | \$29.60  | \$46.40    |
| \$25,000                      | \$2.00  | \$3.00  | \$3.25  | \$4.50  | \$7.50   | \$13.25  | \$22.25  | \$37.00  | \$58.00    |
| \$30,000                      | \$2.40  | \$3.60  | \$3.90  | \$5.40  | \$9.00   | \$15.90  | \$26.70  | \$44.40  | \$69.60    |
| \$35,000                      | \$2.80  | \$4.20  | \$4.55  | \$6.30  | \$10.50  | \$18.55  | \$31.15  | \$51.80  | \$81.20    |
| \$40,000                      | \$3.20  | \$4.80  | \$5.20  | \$7.20  | \$12.00  | \$21.20  | \$35.60  | \$59.20  | \$92.80    |
| \$45,000                      | \$3.60  | \$5.40  | \$5.85  | \$8.10  | \$13.50  | \$23.85  | \$40.05  | \$66.60  | \$104.40   |
| \$50,000                      | \$4.00  | \$6.00  | \$6.50  | \$9.00  | \$15.00  | \$26.50  | \$44.50  | \$74.00  | \$116.00   |
| \$55,000                      | \$4.40  | \$6.60  | \$7.15  | \$9.90  | \$16.50  | \$29.15  | \$48.95  | \$81.40  | \$127.60   |
| \$60,000                      | \$4.80  | \$7.20  | \$7.80  | \$10.80 | \$18.00  | \$31.80  | \$53.40  | \$88.80  | \$139.20   |



## Voluntary Life Cost Illustration *continued*

|                               | < 30   | 30–34   | 35–39   | 40–44   | 45–49   | 50–54   | 55–59   | 60–64    | 65–69†   |
|-------------------------------|--------|---------|---------|---------|---------|---------|---------|----------|----------|
| \$65,000                      | \$5.20 | \$7.80  | \$8.45  | \$11.70 | \$19.50 | \$34.45 | \$57.85 | \$96.20  | \$150.80 |
| \$70,000                      | \$5.60 | \$8.40  | \$9.10  | \$12.60 | \$21.00 | \$37.10 | \$62.30 | \$103.60 | \$162.40 |
| \$75,000                      | \$6.00 | \$9.00  | \$9.75  | \$13.50 | \$22.50 | \$39.75 | \$66.75 | \$111.00 | \$174.00 |
| \$80,000                      | \$6.40 | \$9.60  | \$10.40 | \$14.40 | \$24.00 | \$42.40 | \$71.20 | \$118.40 | \$185.60 |
| \$85,000                      | \$6.80 | \$10.20 | \$11.05 | \$15.30 | \$25.50 | \$45.05 | \$75.65 | \$125.80 | \$197.20 |
| \$90,000                      | \$7.20 | \$10.80 | \$11.70 | \$16.20 | \$27.00 | \$47.70 | \$80.10 | \$133.20 | \$208.80 |
| \$95,000                      | \$7.60 | \$11.40 | \$12.35 | \$17.10 | \$28.50 | \$50.35 | \$84.55 | \$140.60 | \$220.40 |
| \$100,000                     | \$8.00 | \$12.00 | \$13.00 | \$18.00 | \$30.00 | \$53.00 | \$89.00 | \$148.00 | \$232.00 |
| <b>Policy Election Amount</b> |        |         |         |         |         |         |         |          |          |
| Child(ren)                    |        |         |         |         |         |         |         |          |          |
| \$10,000                      | \$1.47 | \$1.47  | \$1.47  | \$1.47  | \$1.47  | \$1.47  | \$1.47  | \$1.47   | \$1.47   |

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

Premiums for Voluntary Life Increase in five-year increments

Infant coverage is limited for the first two weeks of infant's life.

**Spouse/DP coverage premium is based on Employee age.**

†Benefit reductions apply.

### Manage Your Benefits:

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

## 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-ADCLI-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.

**Enhanced AD&D:** A loss may be defined as death, quadriplegia, loss of speech and hearing, loss of cognitive function, comatose state in excess of one month, hemiplegia or paraplegia. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

*This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.*

# WillPrep Services

## Special bonus for participants in voluntary life plan

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

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

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

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

\*The Option of an attorney prepared will is available for a small fee.

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

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## Short-Term Disability Benefit Summary

**Group Number:** 00555836

**A Disability insurance plan through Guardian provides:**

- Income protection while you are unable to work
- Affordable group rates
- Fast claim payments paid directly to you that can help pay for expenses while you recover
- Extensive resources and support to help you get back to work and a productive life

### About Your Benefits:

| Short-Term Disability   |   |
|---|---|
| <b>Coverage amount</b>  | 60% of salary to maximum \$600/week                   |
| <b>Maximum payment period:</b> Maximum length of time you can receive disability benefits.  | 25 weeks  |
| <b>Accident benefits begin:</b> The length of time you must be disabled before benefits begin.  | Day 8   |
| <b>Illness benefits begin:</b> The length of time you must be disabled before benefits begin.   | Day 8   |
| <b>Evidence of Insurability:</b> A health statement requiring you to answer a few medical history questions.  | Health Statement may be required                      |
| <b>Guarantee Issue:</b> 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 \$600 in coverage                  |
| <b>Minimum work hours/week:</b> Minimum number of hours you must regularly work each week to be eligible for coverage.  | Planholder Determines                                 |
| <b>Pre-existing conditions:</b> A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. | 3 months look back; 12 months after 2 week limitation |
| <b>Premium waived if disabled:</b> Premium will not need to be paid when you are receiving benefits.  | Yes   |

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

- **Earnings definition:** Your covered salary excludes bonuses and commissions.

#### Manage Your Benefits:

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

## A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Short-Term Disability coverage, benefits for a disability caused or contributed to by a pre-existing condition are limited, unless the disability starts after you have been insured under this plan for a specified period of time. We do not pay short term disability benefits for any job-related or on-the-job injury, or conditions for which Workers' Compensation benefits are payable.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or

intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.

- This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA.

Contract # GP-I-STD-15-1.0 et al.

***This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.***



## BENEFITS OFFSET NOTICE

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

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

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

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**Critical Illness Benefit Summary**
**Group Number:** 00555836

**A Critical Illness insurance plan through Guardian provides:**

- A cash benefit for a range of covered serious illnesses such as Cancer, Stroke and Heart Attack, in addition to whatever your medical insurance may cover
- Payments are made directly to you and can be used for any purpose

**About Your Benefits:**
**CRITICAL ILLNESS**
**Benefit Amount(s)**

Employee may choose a lump sum benefit up to \$20,000. Please see your cost illustration for a full list of available benefit amounts.

**CONDITIONS**
**Cancer**
**1st OCCURRENCE**
**2nd OCCURRENCE**

Invasive Cancer

100%

100%

Carcinoma In Situ

30%

0%

Benign Brain Tumor

75%

0%

**Vascular**

Heart Attack

100%

100%

Stroke

100%

100%

Heart Failure

100%

100%

Coronary Arteriosclerosis

30%

0%

**Other**

Organ Failure

100%

100%

Kidney Failure

100%

100%

**ADDITIONAL CONDITIONS**
**1st OCCURRENCE ONLY**

Addison's Disease

30%

ALS (Lou Gehrig's Disease)

100%

Alzheimer's Disease

50%

Coma

100%

Huntington's Disease

30%

Loss of Hearing

100%

Loss of Sight

100%

Loss of Speech

100%

Multiple Sclerosis

30%

Parkinson's Disease

100%

Permanent Paralysis

50% for 1 limb, 100% for 2 limbs

Severe Burns

100%

**Childhood Conditions**
**1st OCCURRENCE ONLY**

Cerebral Palsy

100%

Cleft Lip/Palate

100%

Club Foot

100%

Cystic Fibrosis

100%

Down's Syndrome

100%

Muscular Dystrophy

100%

Spina Bifida

100%

**CRITICAL ILLNESS**

|  |  |
|--|--|
| Type I Diabetes  | 100%   |
| <b>Spouse/Domestic Partner Benefit</b>   | May choose a lump sum benefit of \$5,000 to \$10,000 in \$5,000 increments up to 50% of the employee's lump sum benefit.   |
| <b>Child Benefit-</b> children age Birth to 26 years   | 25% of employee's lump sum benefit   |
| <b>Benefit Reductions:</b> Benefits are reduced by a certain percentage as an employee ages  | 50% at age 70  |
| <b>Guarantee Issue:</b> 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 or the annual open enrollment period. | <p>We Guarantee Issue up to:<br/>\$20,000</p> <p>For a spouse:<br/>\$10,000</p> <p>For a child: All Amounts</p> <p><b>Health questions are required if the elected amount exceeds the Guarantee Issue.</b></p> |
| <b>Portability:</b> Allows you to take your Critical Illness coverage with you if you terminate employment.  | Included   |
| <b>Pre-Existing Condition Limitation:</b> A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.                          | 12 months prior, 12 months after   |

**WELLNESS BENEFIT**

|                         |       |
|-------------------------|-------|
| Employee Per Year Limit | \$100 |
| Spouse Per Year Limit   | \$100 |
| Child Per Year Limit    | \$100 |

**Condition Definitions**

- **Stroke:** Stroke must be severe enough to cause neurological deficits at least 30 days after the event.
- **Heart Failure:** An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- **Coronary Arteriosclerosis:** Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- **Organ Failure:** Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- **Kidney Failure:** An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

**Manage Your Benefits:**

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

## EXCLUSIONS AND LIMITATIONS

### A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR CRITICAL ILLNESS:

We will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category.

We will not pay benefits for a Second occurrence (recurrence) of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 6 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

We do not pay benefits for claims 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.

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 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

Guardian's Critical Illness plan does not provide comprehensive medical coverage. It is a basic or limited benefit and is not intended to cover all medical expenses. It does not provide "basic hospital," "basic medical," or "medical" insurance as defined by the New York State Insurance Department.

Health questions are required on those enrolling outside of the initial enrollment period or annual open enrollment period. The coverage will not be effective until approved by a Guardian underwriter.

*The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. See your certificate booklet for a full listing of exclusions & limitations..*

*If Critical Illness 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..*

Contract # GP-I-CI-I4

**This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.**

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## Accident Benefit Summary

**Group Number:** 00555836

**Accident insurance through Guardian provides you:**

- A cash benefit for covered injuries, treatments and services, in addition to whatever your medical plan may cover
- Payments go directly to you, not the doctor
- Easy enrollment with no medical questions

**About Your Benefits:**

| ACCIDENT  |   |
|---|---|
| <b>COVERAGE - DETAILS</b>   |   |
| <b>Accident Coverage Type</b>   | On and Off Job  |
| <b>Portability</b> - Allows you to take your Accident coverage with you if you terminate employment.  | Included  |
| <b>ACCIDENTAL DEATH AND DISMEMBERMENT</b>   |   |
| <b>Benefit Amount(s)</b>  | Employee \$50,000<br>Spouse \$25,000<br>Child \$5,000   |
| <b>Catastrophic Loss</b>  | Quadriplegia, Loss of speech & hearing (both ears),<br>Loss of Cognitive function: 100% of AD&D<br>Hemiplegia & Paraplegia: 50% of AD&D |
| <b>Common Carrier</b>   | 200% of AD&D benefit  |
| <b>Common Disaster</b>  | 200% of Spouse AD&D benefit   |
| <b>Dismemberment</b> - Hand, Foot, Sight  | Single: 50% of AD&D benefit<br>Multiple: 100% of AD&D benefit   |
| <b>Dismemberment</b> - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot   | 25% of AD&D benefit   |
| <b>Seatbelts and Airbags</b>  | Seatbelts: \$10,000 & Airbags: \$15,000   |
| <b>Reasonable Accommodation to Home or Vehicle</b>  | \$2,500   |
| <b>WELLNESS BENEFIT</b> - Per Year Limit  | \$100   |
| <b>Child(ren) Age Limits</b>  | Children age birth to 26 years  |
| <b>FEATURES</b>   |   |
| Accident Emergency Room Treatment   | \$200   |
| Accident Follow-Up Visit - Doctor   | \$75 up to 6 treatments   |
| Air Ambulance   | \$1,500   |
| Ambulance   | \$200   |
| Appliance - Wheelchair, leg or back brace, crutches, walker, walking boot that extends above the ankle or brace for the neck.   | \$125   |
| Blood/Plasma/Platelets  | \$300   |
| Burns (2nd Degree/3rd Degree)   | 9 sq inches to 18 sq inches: \$0/\$2,000<br>18 sq inches to 35 sq inches: \$1,000/\$4,000<br>Over 35 sq inches: \$3,000/\$12,000        |
| Burn - Skin Graft   | 50% of burn benefit   |
| Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child is participating in an organized sport that is governed by an organization and requires formal registration to participate. | 20% increase to child benefits  |
| Chiropractic Visits   | \$50 per visit up to 6 visits   |
| Coma  | \$12,500  |
| Concussions   | \$100   |

Benefit information illustrated within this material reflects the plan covered by Guardian as of 02/17/2020

ALL ELIGIBLE EMPLOYEES ELECTING SHORT TERM DISABILITY 25 WEEK DURATION Benefit Summary

The Guardian Life Insurance Company of America, New York, NY

**FEATURES (Cont.)**

|   |   |
|---|---|
| Dislocations  | Schedule up to \$4,800                            |
| Diagnostic Exam (Major)   | \$200   |
| Emergency Dental Work   | \$400/Crown, \$100/Extraction                     |
| Epidural pain management  | \$100, 2 times per accident                       |
| Eye Injury  | \$300   |
| Family Care   | \$20/day up to 30 days                            |
| Fracture  | Schedule up to \$6,000                            |
| Hospital Admission  | \$1,250   |
| Hospital Confinement  | \$250/day - up to 1 year                          |
| Hospital ICU Admission  | \$2,500   |
| Hospital ICU Confinement  | \$500/day - up to 15 days                         |
| Initial Physician's office/Urgent Care Facility Treatment   | \$100   |
| Joint Replacement (hip/knee/shoulder)   | \$3,500/\$1,750/\$1,750                           |
| Knee Cartilage  | \$750   |
| Laceration  | Schedule up to \$500                              |
| Lodging - The hospital must be more than 50 miles from the insured's residence.   | \$150/day, up to 30 days for companion hotel stay |
| Occupational or Physical Therapy  | \$35/day up to 10 days                            |
| Prosthetic Device/Artificial Limb   | 1: \$750<br>2 or more: \$1,500                    |
| Rehabilitation Unit Confinement   | \$150/day up to 15 days                           |
| Ruptured Disc With Surgical Repair  | \$750   |
| Surgery   | Schedule up to \$1,500<br>Hernia: \$200           |
| Surgery - Exploratory or Arthroscopic   | \$350   |
| Tendon/Ligament/Rotator Cuff  | 1: \$750<br>2 or more: \$1,500                    |
| 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. | \$600, 3 times per accident                       |
| X - Ray   | \$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.
- **Accident Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.

*This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.*

## Manage Your Benefits:

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

## 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; treatment rendered or hospital confinement outside the United States or Canada; 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, 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-I-AC-IC-12

*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.*

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**Effective:**
**Group Number:** 00555836

## Hospital Indemnity Benefit Summary

**A Hospital Indemnity insurance plan through Guardian provides:**

- A cash benefit when you are admitted to a hospital, whether or not these charges are covered by your medical plan
- Benefit payments sent directly to you and can be used for any purpose – from covering medical copays and deductibles to paying for everyday expenses such as the mortgage, groceries and utilities
- Simple enrollment with no health or medical questions to answer
- Ability to take the coverage with you if you change jobs or retire

**About Your Benefits:**

| Hospital Indemnity  |  |
|---|--|
|   | Option 1   |
| <b>Coverage Details</b>   |  |
| <b>Benefits</b>   |  |
| Hospital/ICU Admission  | \$2,000 per admission, limited to 1 admission(s) per insured and 3 admission(s) per covered family per benefit year. |
| Hospital/ICU Confinement  | \$200/\$200 per day, limited to 30 day(s) per insured per benefit year.  |
| <b>Pre-Existing Conditions Limitation</b> - A pre-existing condition includes any condition 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 (See Limitations and Exclusions section for details on treatment of maternity)                        |
| <b>Portability</b> - Allows you to take your Hospital Indemnity coverage with you if you terminate employment.  | Included   |
| <b>Child(ren) Age Limits</b>  | Children age birth to 26 years   |
| Applicants over the age of 69 are not eligible to enroll in the Hospital Indemnity coverage.  |  |

## UNDERSTANDING YOUR BENEFITS – HOSPITAL INDEMNITY

Hospital Admission & Hospital ICU Admission benefits are not payable on the same day.

Premium will be waived if you are hospitalized for more than 30 days.

Hospital admission or confinement benefits are not payable for a newborn unless the child is admitted to the Neonatal ICU.

Hospital/ICU confinement benefits are not payable on the same day as Hospital/ICU admission benefit.

After initial enrollment, Hospital Indemnity coverage will continue as long as an insured is actively at work.

**Manage Your Benefits:**

Go to [www.GuardianAnytime.com](http://www.GuardianAnytime.com) to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.  
[www.guardiananytime.com](http://www.guardiananytime.com).

## LIMITATIONS AND EXCLUSIONS:

In order to be eligible for coverage: Employees must be legally working: (a) in the United States or (b) outside the United States, for a US based employer, in a country or region approved by Guardian.

An applicant must enroll within 31 days of the coverage effective date. An open enrollment will occur each year during a 30 day time period specified by the policyholder. If an applicant does not enroll during their initial enrollment period, he/she may not enroll until the next open enrollment period.

This Plan will not pay benefits for:

- Treatment relating to a covered person: taking part in any war or act of war (including service in the armed forces), commission of or attempt to commit a felony, an act of terrorism, or participating in an illegal occupation, riot or insurrection.
- Suicide or any intentionally self-inflicted injury

Elective surgery;

Surgery to correct vision or hearing, unless medically necessary surgery for glaucoma, cataracts or other sickness or injury;

Dental care, dental xrays, or dental treatment;

Gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures. This exclusion does not apply to completion of a weight reduction program that may be payable under the Health Screening benefit ;

Rest cures or custodial care, or treatment of sleep disorders;

Services, treatment or supplies rendered outside the United States or Canada;

Cosmetic surgery. This Exclusion does not apply to reconstructive surgery:

(a) on an injured part of the body following infection or disease of the involved part;

(b) of a congenital disease or anomaly of a covered dependent newborn or adopted infant; or

(c ) on a nondiseased breast to restore and achieve symmetry between two breasts following a covered Mastectomy;

Treatment or removal of warts, moles, boils, skin blemishes or birthmarks, bunions, acne, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;

Service, treatment or loss related to alcoholism or drug addiction, except for drugs prescribed by the Covered Person's Doctor and taken as prescribed;

Care or treatment for mental or nervous disorders;

Services, treatment or loss rendered in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;

Services or treatment Provided by a Doctor, Nurse or any other person who is employed or retained by a Covered Person or who is a Covered Person's Spouse, parent, brother, sister, child, Domestic Partner or partner in a civil union.

Surgery and treatment, procedures, products or services that are experimental or investigative.

Hospital Confinement and/or Hospital Admission and Inpatient Surgery due to any Covered Person's giving birth within the first 9 months after the Covered Person's effective date under this Plan as a result of a normal pregnancy, including cesarean section. Complications of Pregnancy will be covered to the same extent as any other Covered Sickness

Treatment of a Covered Dependent Child's Children;

Sickness or Injury sustained while on active duty in the armed forces of any country. This does not include Reserve or National Guard duty for training.

GP-I-HI-15

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# Easy-To-Use Online Link Provides Faster Processing

Guardian's online electronic Evidence of Insurability (EOI) provides an alternative to paper EOI forms when you need to provide additional information for requested coverage.

## Common situations include:

- Answering yes to one of the health questions on your enrollment form
- Enrolling for coverage in excess of the guaranteed issue amount
- Requesting coverage after your initial eligibility for coverage

## Electronic Evidence of Insurability can be used for the following coverages\*:

- Basic Life
- Voluntary Life
- Short Term Disability
- Long Term Disability

## Guardian's online EOI form offers several advantages:

- Your personal data is kept secure
- No errors due to hand-written data
- Faster submission of your completed form

## Accessing the electronic Evidence of Insurability link

Simply go to : [guardiananytime.com/eoi](http://guardiananytime.com/eoi)

**No registration is required. The process is easy and secure, simply follow the steps outlined below:**

- 1 Fill in your Group ID #
- 2 Enter your personal information
- 3 Answer the health questions
- 4 Electronically sign your name and click 'Submit'

## Guardian receives the completed EOI form in minutes!

- 1 Guardian's Medical Underwriting Team moves through the EOI process and will contact you with any questions.
- 2 We will send you a letter in the mail regarding the status of your request for coverage.
- 3 We will notify your employer of the outcome of your request only if your coverage amount is changed.

**If you have questions about the process or if you need to provide evidence of insurability, please contact your Plan Administrator.**

**The Guardian Life Insurance Company of America**  
New York, NY

[guardiananytime.com](http://guardiananytime.com)

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

Guardian® is a registered service mark of The Guardian Life Insurance Company of America.

# WorkLifeMatters

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

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

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

| WorkLifeMatters can offer help with:   |  |  |
|--|--|--|
| <b>Education</b> <ul style="list-style-type: none"><li>▪ Admissions testing &amp; procedures</li><li>▪ Adult re-entry programs</li><li>▪ College Planning</li><li>▪ Financial aid resources</li><li>▪ Finding a pre-school</li></ul> | <b>Dependent Care &amp; Care Giving</b> <ul style="list-style-type: none"><li>▪ Adoption Assistance</li><li>▪ Before/after school programs</li><li>▪ Day Care/Elder Care</li><li>▪ Elder care</li><li>▪ In-home services</li></ul> | <b>Legal and financial</b> <ul style="list-style-type: none"><li>▪ Basic tax planning</li><li>▪ Credit &amp; collections</li><li>▪ Debt Counseling</li><li>▪ Home buying</li><li>▪ Immigration</li></ul> |
| <b>Lifestyle &amp; Fitness Management</b> <ul style="list-style-type: none"><li>▪ Anxiety &amp; depression</li><li>▪ Divorce &amp; separation</li><li>▪ Drugs &amp; alcohol</li></ul>  | <b>Working Smarter</b> <ul style="list-style-type: none"><li>▪ Career development</li><li>▪ Effective managing</li><li>▪ Relocation</li></ul>  |  |

For more information about WorkLifeMatters, go to [www.ibhworklife.com](http://www.ibhworklife.com); User Name: Matters; Password: wlm70101

WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters Program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters Program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.

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

**Please print clearly and mark carefully.**

|  |                                    |                           |
|--|------------------------------------|---------------------------|
| Employer Name: <b>FREEDOM SENIOR MANAGEMENT, LLC</b>   | Group Plan Number: <b>00555836</b> | Benefits Effective: _____ |
| PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Re-Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change<br><input type="checkbox"/> Increase Amount <input type="checkbox"/> Family Status Change |                                    |                           |

|   |                 |                      |   |
|---|-----------------|----------------------|---|
| Class: ALL ELIGIBLE EMPLOYEES<br>ELECTING SHORT TERM DISABILITY<br>25 WEEK DURATION | Division: _____ | Subtotal Code: _____ | (Please obtain this from your Employer) |
|---|-----------------|----------------------|---|

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

|  |  |                              |                  |
|--|--|------------------------------|------------------|
| <b>About Your Job:</b>   |  | Hours worked per week: _____ | Job Title: _____ |
| Work Status:<br><input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra/State Continuation | Date of full time hire: ____ - ____ - ____ | Annual Salary: \$ _____      |                  |

|   |   |  |  |   |
|---|---|--|--|---|
| <b>About Your Family:</b> Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew. |   |  |  |   |
| Spouse (First, MI, Last Name)<br><br>Address/City/State/Zip:<br><br>Phone: (    )    -  | Gender<br><input type="checkbox"/> M <input type="checkbox"/> F | Social Security Number<br>____ - ____ - ____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ |  |   |
| Child/Dependent 1:<br><br>Address/City/State/Zip:<br><br>Phone: (    )    -   | <input type="checkbox"/> Add <input type="checkbox"/> Drop      | Gender<br><input type="checkbox"/> M <input type="checkbox"/> F                                      | Social Security Number<br>____ - ____ - ____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br><input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled<br><input type="checkbox"/> Non standard dependent |
| Child/Dependent 2:<br><br>Address/City/State/Zip:<br><br>Phone: (    )    -   | <input type="checkbox"/> Add <input type="checkbox"/> Drop      | Gender<br><input type="checkbox"/> M <input type="checkbox"/> F                                      | Social Security Number<br>____ - ____ - ____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br><input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled<br><input type="checkbox"/> Non standard dependent |

|   |  |   |  |   |
|---|--|---|--|---|
| Child/Dependent 3:<br><br>Address/City/State/Zip:<br><br>Phone: (    ) -    - | <input type="checkbox"/> Add <input type="checkbox"/> Drop | Gender<br><input type="checkbox"/> M <input type="checkbox"/> F | Social Security Number<br>____ - ____ - ____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br><input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled<br><input type="checkbox"/> Non standard dependent |
| Child/Dependent 4:<br><br>Address/City/State/Zip:<br><br>Phone: (    ) -    - | <input type="checkbox"/> Add <input type="checkbox"/> Drop | Gender<br><input type="checkbox"/> M <input type="checkbox"/> F | Social Security Number<br>____ - ____ - ____<br><br>Date of Birth (mm-dd-yyyy)<br>____ - ____ - ____ | Status (check all that apply)<br><input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled<br><input type="checkbox"/> Non standard dependent |

|   |   |
|---|---|
| <b>Drop Coverage:</b><br><input type="checkbox"/> Drop Employee <input type="checkbox"/> Drop Dependents<br>The date of withdrawal cannot be prior to the date this form is completed and signed.<br>Last Day of Coverage: ____ - ____ - ____<br><input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement<br>Last Day Worked: ____ - ____ - ____<br><input type="checkbox"/> Other Event: _____<br>Date of Event: ____ - ____ - ____  | <b>Coverage Being Dropped:</b><br><input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)<br><input type="checkbox"/> Vision <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)<br><input type="checkbox"/> Basic Life<br><input type="checkbox"/> Voluntary Life <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)<br><input type="checkbox"/> Critical Illness<br><input type="checkbox"/> Accident <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)<br><input type="checkbox"/> Hospital Indemnity <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)<br><input type="checkbox"/> Short Term Disability |
| <b>Loss Of Other Coverage:</b><br>I and/or my dependents were previously covered under <u>another insurance plan</u> . Loss of coverage was due to:<br><input type="checkbox"/> Termination of Employment: ____ - ____ - ____<br><input type="checkbox"/> Divorce ____ - ____ - ____<br><input type="checkbox"/> Death of Spouse ____ - ____ - ____<br><input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____<br><b>Coverage Lost</b> <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:<br><input type="checkbox"/> Covered under another insurance plan<br><input type="checkbox"/> Other _____<br>(additional information may be required)   |

|  |                          |                          |                           |                                   |
|--|--------------------------|--------------------------|---------------------------|-----------------------------------|
| <b>Dental Coverage:</b> You must be enrolled to cover your dependents. Check only one box.   |                          |                          |                           |                                   |
|  | Employee Only            | EE & Spouse              | EE & Dependent/Child(ren) | EE, Spouse & Dependent/Child(ren) |
| Option 1: LOW  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/>          |
| Option 2: HIGH   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/>          |
| <input type="checkbox"/> I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:<br><input type="checkbox"/> I am covered under another Dental plan<br><input type="checkbox"/> My spouse is covered under another Dental plan<br><input type="checkbox"/> My dependents are covered under another Dental plan |                          |                          |                           |                                   |

|  |                          |                          |                           |                                   |
|--|--------------------------|--------------------------|---------------------------|-----------------------------------|
| <b>Vision Coverage:</b> You must be enrolled to cover your dependents. Check only one box.   |                          |                          |                           |                                   |
|  | Employee Only            | EE & Spouse              | EE & Dependent/Child(ren) | EE, Spouse & Dependent/Child(ren) |
| Full Feature - Designer  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/>          |
| <input type="checkbox"/> I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:<br><input type="checkbox"/> I am covered under another Vision plan<br><input type="checkbox"/> My spouse is covered under another Vision plan<br><input type="checkbox"/> My dependents are covered under another Vision plan |                          |                          |                           |                                   |

**Basic Life Coverage:***Benefit reductions apply. Please see plan administrator.***Policy Amount**

Employee Only

☒ 100% of your annual salary to a maximum of \$50,000

The Guarantee Issue Amount is \$50,000.

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

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ %

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

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ %

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

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

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

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

**Important Notes:**

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

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

- |                                    |                                    |                                    |                                     |                                    |                                    |
|------------------------------------|------------------------------------|------------------------------------|-------------------------------------|------------------------------------|------------------------------------|
| <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 \$100,000\*, 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 |                                   |                                   |                                    |                                   |

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

## LIFE INSURANCE *continued*

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

#### Policy Amount

☐ \$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 for Voluntary Life.

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

#### Primary Beneficiaries:

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ %

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

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ %

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

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

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

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

### Short-Term Disability (STD) Coverage:

#### Weekly Benefit

☐ 60% of salary to a maximum of \$600

☐ I do not want this coverage.

### Critical Illness Coverage: You must be enrolled to cover your dependents

*Benefit reductions apply. Please see plan administrator.*

#### Employee

Insurance Amount: ☐ \$10,000 ☐ \$20,000

☐ I do not want this coverage.

#### Spouse

Insurance Amount: Up to 50% of the employee's amount to a maximum of \$10,000

☐ \$5,000 ☐ \$10,000

☐ I do not want this coverage.

#### Dependent/Child(ren)

Insurance Amount: ☐ 25% of the employee's amount

☐ I do not want this coverage.

Have you used any form of tobacco in the past 6 months (e.g. pipe, chewing tobacco) and/or have you smoked cigarettes in the past 12 months?

Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No



**IMPORTANT NOTES:**

You may be required to complete an additional evidence of insurability form for Critical Illness if you are enrolling after any initial eligibility enrollment period.

**Accident Coverage** You must be enrolled to cover your dependents.

|                      |                          |                          |                              |                                      |
|----------------------|--------------------------|--------------------------|------------------------------|--------------------------------------|
| Your Monthly premium | Employee Only            | EE & Spouse              | EE &<br>Dependent/Child(ren) | EE, Spouse &<br>Dependent/Child(ren) |
|                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/>             |

☐ I do not want this coverage.

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

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ % \_\_\_\_\_

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

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ % \_\_\_\_\_

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

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

Phone: ( ) - \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

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

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

**Hospital Indemnity Coverage** You must be enrolled to cover your dependents. Check only one box.

|                      |                          |                          |                          |                          |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Your Monthly premium | Employee Only            | EE & Spouse              | EE & Child(ren)          | EE, Spouse & Child(ren)  |
|                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Applicants over the age of 69 are not eligible to enroll in the Hospital Indemnity coverage.**

☐ I do not want this coverage. ☐ I do not want this coverage. ☐ I do not want this coverage. ☐ I do not want this coverage.

**Important Notes:**

This is a limited plan of Hospital Indemnity insurance. It is a supplement to health insurance. It is not a substitute for, hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

**Signature**

- An employee's decision to elect Vision and/or Hospital Indemnity not elect Vision and/or Hospital Indemnity must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in Vision and/or Hospital Indemnity coverage, they are not eligible to enroll until the plan's next Open Enrollment period..
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.

- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

**Any person who 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.**

**The laws of New York require the following statement appear: If you are not a resident of New York this statement does not apply to you: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)**

**SIGNATURE OF EMPLOYEE** X \_\_\_\_\_

**DATE** \_\_\_\_\_

Enrollment Kit 00555836, 0002, EN