GUARDIAN®

Group Number: 00533116

CENTENARY COLLEGE OF LOUISIANA

ALL OTHER ELIGIBLE EMPLOYEES

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
- Long Term Disability
- Critical Illness
- Accident

GUARDIAN®

Welcome

Dear CENTENARY COLLEGE OF LOUISIANA Employee,

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

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

CENTENARY COLLEGE OF LOUISIANA

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CENTENARY COLLEGE OF LOUISIANA

Dental Benefit Summary

Group Number: 00533116

About Your Benefits:

Taking care of your teeth can be expensive. That's why the right dental insurance is so important — it not only pays for preventive care that can keep you and your family healthy, but it also helps pay for more extensive, costly and often unexpected expenses — such as fillings, crowns and root canals. Plus, you save money and have the assurance that you are getting the right care when you use one of our contracted dentists. Guardian been providing outstanding dental plans to millions of Americans for more than 50 years. When you enroll with Guardian, you have access to one of the nation's largest dental networks offering significant discounts so you know there's always high-quality, affordable dental care close by. From preventive checkups and cleanings, to comprehensive oral care treatments, we have you covered.

With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

Your Dental Plan	**PPO**	
Your Network is	DentalGuard Preferred	
Calendar year deductible	*In-Network*	*Out-of-Network*
Individual	$50	$50
Family limit	3 per family	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%
Basic Care	90%	80%
Major Care	60%	50%
Orthodontia	50%	50%
Annual Maximum Benefit	$1500	$1500
Maximum Rollover	Yes	
Rollover Threshold	$700	
Rollover Amount	$350	
Rollover In-network Amount	$500	
Rollover Account Limit	$1250	
Lifetime Orthodontia Maximum	$1500	
Dependent Age Limits	26	

A Sample of Services Covered by Your Plan:

		PPO *Plan pays (on average)*	
		In-network	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 19	
	Oral Exams	100%	100%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Anesthesia*	90%	80%
	Fillings‡	90%	80%
	Simple Extractions	90%	80%
Major Care	Bridges and Dentures	60%	50%
	Inlays, Onlays, Veneers**	60%	50%
	Perio Surgery	60%	50%
	Periodontal Maintenance	60%	50%
	Frequency:	Once Every 6 Months (Standard)	
	Repair & Maintenance of Crowns, Bridges & Dentures	60%	50%
	Root Canal	60%	50%
	Scaling & Root Planing (per quadrant)	60%	50%
	Single Crowns	60%	50%
	Surgical Extractions	60%	50%
Orthodontia	Orthodontia	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 filing 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. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

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

Manage Your Benefits:

Go to 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
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-1-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

Dental Maximum Rollover®

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
$1500	$700	$350	$500	$1250
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed $2,750 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

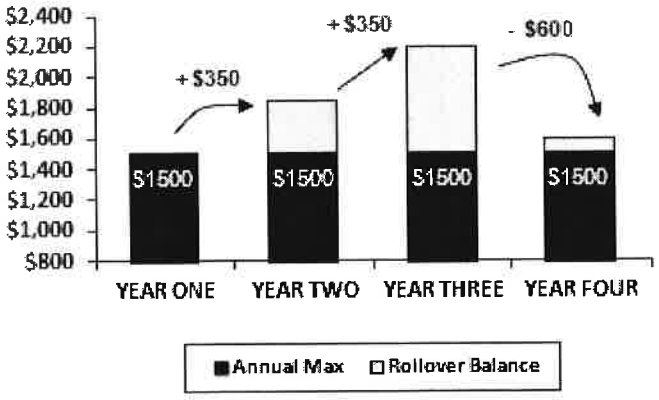
Here's how the benefits work:

YEAR ONE: Jane starts with a $1,500 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $700 Threshold, she receives a $350 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $1,850. This year, she submits $50 in claims and receives an additional $350 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $2,200. This year, she submits $2,100 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is $1,600 ($1,500 Plan Annual Maximum + $100 remaining in her Maximum Rollover Account).



For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

NOTES:

You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form #GP-1-DG2000, et al.

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GUARDIAN®

CENTENARY COLLEGE OF LOUISIANA

Vision Benefit Summary

Group Number: 00533116

About Your Benefits:

Eye care is a vital component of a healthy lifestyle. With vision insurance, having regular exams and purchasing contacts or glasses is simple and affordable. The coverage is inexpensive, yet the benefits can be significant! Guardian provides rich, flexible plans that allow you to safeguard your health while saving you money. Review your plan options and see why vision insurance may be a great benefit for you.

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 Wal-Mart®, JCPenney®, Sears®, Target®, Sam's Club®, Pearle®, and Visionworks®.

Your Vision Plan	**Full Feature - Designer**	
Your Network is	Davis Vision	
Your Monthly premium	**$ 8.45**	
You and spouse	$ 16.90	
You and child(ren)	$ 18.24	
You, spouse and child(ren)	$ 26.52	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for non-formulary elective contact lenses)*	$ 25	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
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 $130*2	Amount over $48
Contact Lenses *(Elective and conventional)*	85% of amount over $130*	Amount over $105
Contact Lenses *(Planned replacement and disposable)*	85% of amount over $130*	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
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every calendar year	
Network discounts *(glasses and contact lens professional service)*	Applies to first purchase & courtesy discount from most providers on subsequent purchases.	
Dependent Age Limits	26	

Visit www.GuardianAnytime.com 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.
- 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 Wal-mart and Sam's Club locations, discounts do not apply. Members will pay 100% of the amount over their allowance.
- 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.
- [2]Extra $50 at Visionworks stores

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

Manage Your Benefits:

Go to 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-1-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.

GUARDIAN®

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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.

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 disclosure 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.

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

GUARDIAN

CENTENARY COLLEGE OF LOUISIANA

Life Benefit Summary

Group Number: 00533116

About Your Benefits:

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

What Your Benefits Cover:

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides Basic Life Coverage for all full time employees in the amount of 100% of your annual salary, to a maximum of $250,000.	$10,000 increments to a maximum of $500,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Enhanced Accidental Death and Dismemberment coverage.	Employee, Spouse & Child(ren) coverage. Maximum 1 times life amount.
Spouse‡ Benefit	Your spouse is eligible for coverage in the amount of $5,000.	$5,000 increments to a maximum of $250,000. See Cost Illustration page for details.
Child Benefit	Your dependent children ages 14 days to 26, are eligible for coverage in the amount of $2,000. See enrollment form for details.	Your dependent children age 14 days to 26 years. You may elect one of the following benefit options: $1,000, $5,000, $10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	Guarantee Issue coverage up to $250,000 per employee	We Guarantee Issue coverage up to: Employee $130,000. Spouse $50,000. Dependent children $10,000. An Additional $100,000 per employee, $25,000 for a spouse can be obtained with a "No" response to the Health question (on your enrollment form). Evidence of Insurability is required if the elected amount exceeds the Guarantee Issue plus Additional amount.

	BASIC LIFE	VOLUNTARY TERM LIFE
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take your coverage with you if you terminate employment.	Yes, with age and other restrictions, including evidence of insurability	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met	No
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	33% at age 65, 66% at age 70	33% at age 70, 66% at age 75

Subject to coverage limits

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

Manage Your Benefits:

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

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

Monthly premiums displayed. Cost of AD&D is included.

Policy Election Amount	Policy Election Cost Per Age Bracket								
Employee	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$20,000	$1.92	$2.26	$2.78	$3.14	$3.48	$4.88	$7.30	$13.04	$19.86
$30,000	$2.88	$3.39	$4.17	$4.71	$5.22	$7.32	$10.95	$19.56	$29.79
$40,000	$3.84	$4.52	$5.56	$6.28	$6.96	$9.76	$14.60	$26.08	$39.72
$50,000	$4.80	$5.65	$6.95	$7.85	$8.70	$12.20	$18.25	$32.60	$49.65
$60,000	$5.76	$6.78	$8.34	$9.42	$10.44	$14.64	$21.90	$39.12	$59.58
$70,000	$6.72	$7.91	$9.73	$10.99	$12.18	$17.08	$25.55	$45.64	$69.51
$80,000	$7.68	$9.04	$11.12	$12.56	$13.92	$19.52	$29.20	$52.16	$79.44
$90,000	$8.64	$10.17	$12.51	$14.13	$15.66	$21.96	$32.85	$58.68	$89.37
$100,000	$9.60	$11.30	$13.90	$15.70	$17.40	$24.40	$36.50	$65.20	$99.30
$110,000	$10.56	$12.43	$15.29	$17.27	$19.14	$26.84	$40.15	$71.72	$109.23
$120,000	$11.52	$13.56	$16.68	$18.84	$20.88	$29.28	$43.80	$78.24	$119.16
$130,000	$12.48	$14.69	$18.07	$20.41	$22.62	$31.72	$47.45	$84.76	$129.09
$140,000	$13.44	$15.82	$19.46	$21.98	$24.36	$34.16	$51.10	$91.28	$139.02
$150,000	$14.40	$16.95	$20.85	$23.55	$26.10	$36.60	$54.75	$97.80	$148.95
$160,000	$15.36	$18.08	$22.24	$25.12	$27.84	$39.04	$58.40	$104.32	$158.88
$170,000	$16.32	$19.21	$23.63	$26.69	$29.58	$41.48	$62.05	$110.84	$168.81
$180,000	$17.28	$20.34	$25.02	$28.26	$31.32	$43.92	$65.70	$117.36	$178.74
$190,000	$18.24	$21.47	$26.41	$29.83	$33.06	$46.36	$69.35	$123.88	$188.67
$200,000	$19.20	$22.60	$27.80	$31.40	$34.80	$48.80	$73.00	$130.40	$198.60
$210,000	$20.16	$23.73	$29.19	$32.97	$36.54	$51.24	$76.65	$136.92	$208.53
$220,000	$21.12	$24.86	$30.58	$34.54	$38.28	$53.68	$80.30	$143.44	$218.46
$230,000	$22.08	$25.99	$31.97	$36.11	$40.02	$56.12	$83.95	$149.96	$228.39
$240,000	$23.04	$27.12	$33.36	$37.68	$41.76	$58.56	$87.60	$156.48	$238.32
$250,000	$24.00	$28.25	$34.75	$39.25	$43.50	$61.00	$91.25	$163.00	$248.25
$260,000	$24.96	$29.38	$36.14	$40.82	$45.24	$63.44	$94.90	$169.52	$258.18
$270,000	$25.92	$30.51	$37.53	$42.39	$46.98	$65.88	$98.55	$176.04	$268.11
$280,000	$26.88	$31.64	$38.92	$43.96	$48.72	$68.32	$102.20	$182.56	$278.04
$290,000	$27.84	$32.77	$40.31	$45.53	$50.46	$70.76	$105.85	$189.08	$287.97
$300,000	$28.80	$33.90	$41.70	$47.10	$52.20	$73.20	$109.50	$195.60	$297.90
$310,000	$29.76	$35.03	$43.09	$48.67	$53.94	$75.64	$113.15	$202.12	$307.83
$320,000	$30.72	$36.16	$44.48	$50.24	$55.68	$78.08	$116.80	$208.64	$317.76

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$330,000	$31.68	$37.29	$45.87	$51.81	$57.42	$80.52	$120.45	$215.16	$327.69
$340,000	$32.64	$38.42	$47.26	$53.38	$59.16	$82.96	$124.10	$221.68	$337.62
$350,000	$33.60	$39.55	$48.65	$54.95	$60.90	$85.40	$127.75	$228.20	$347.55
$360,000	$34.56	$40.68	$50.04	$56.52	$62.64	$87.84	$131.40	$234.72	$357.48
$370,000	$35.52	$41.81	$51.43	$58.09	$64.38	$90.28	$135.05	$241.24	$367.41
$380,000	$36.48	$42.94	$52.82	$59.66	$66.12	$92.72	$138.70	$247.76	$377.34
$390,000	$37.44	$44.07	$54.21	$61.23	$67.86	$95.16	$142.35	$254.28	$387.27
$400,000	$38.40	$45.20	$55.60	$62.80	$69.60	$97.60	$146.00	$260.80	$397.20
$410,000	$39.36	$46.33	$56.99	$64.37	$71.34	$100.04	$149.65	$267.32	$407.13
$420,000	$40.32	$47.46	$58.38	$65.94	$73.08	$102.48	$153.30	$273.84	$417.06
$430,000	$41.28	$48.59	$59.77	$67.51	$74.82	$104.92	$156.95	$280.36	$426.99
$440,000	$42.24	$49.72	$61.16	$69.08	$76.56	$107.36	$160.60	$286.88	$436.92
$450,000	$43.20	$50.85	$62.55	$70.65	$78.30	$109.80	$164.25	$293.40	$446.85
$460,000	$44.16	$51.98	$63.94	$72.22	$80.04	$112.24	$167.90	$299.92	$456.78
$470,000	$45.12	$53.11	$65.33	$73.79	$81.78	$114.68	$171.55	$306.44	$466.71
$480,000	$46.08	$54.24	$66.72	$75.36	$83.52	$117.12	$175.20	$312.96	$476.64
$490,000	$47.04	$55.37	$68.11	$76.93	$85.26	$119.56	$178.85	$319.48	$486.57
$500,000	$48.00	$56.50	$69.50	$78.50	$87.00	$122.00	$182.50	$326.00	$496.50
Policy Election Amount									
Spouse									
$5,000	$.48	$.57	$.70	$.79	$.87	$1.22	$1.83	$3.26	$4.97
$10,000	$.96	$1.13	$1.39	$1.57	$1.74	$2.44	$3.65	$6.52	$9.93
$15,000	$1.44	$1.70	$2.09	$2.36	$2.61	$3.66	$5.48	$9.78	$14.90
$20,000	$1.92	$2.26	$2.78	$3.14	$3.48	$4.88	$7.30	$13.04	$19.86
$25,000	$2.40	$2.83	$3.48	$3.93	$4.35	$6.10	$9.13	$16.30	$24.83
$30,000	$2.88	$3.39	$4.17	$4.71	$5.22	$7.32	$10.95	$19.56	$29.79
$35,000	$3.36	$3.96	$4.87	$5.50	$6.09	$8.54	$12.78	$22.82	$34.76
$40,000	$3.84	$4.52	$5.56	$6.28	$6.96	$9.76	$14.60	$26.08	$39.72
$45,000	$4.32	$5.09	$6.26	$7.07	$7.83	$10.98	$16.43	$29.34	$44.69
$50,000	$4.80	$5.65	$6.95	$7.85	$8.70	$12.20	$18.25	$32.60	$49.65
$55,000	$5.28	$6.22	$7.65	$8.64	$9.57	$13.42	$20.08	$35.86	$54.62
$60,000	$5.76	$6.78	$8.34	$9.42	$10.44	$14.64	$21.90	$39.12	$59.58
$65,000	$6.24	$7.35	$9.04	$10.21	$11.31	$15.86	$23.73	$42.38	$64.55

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$70,000	$6.72	$7.91	$9.73	$10.99	$12.18	$17.08	$25.55	$45.64	$69.51
$75,000	$7.20	$8.48	$10.43	$11.78	$13.05	$18.30	$27.38	$48.90	$74.48
$80,000	$7.68	$9.04	$11.12	$12.56	$13.92	$19.52	$29.20	$52.16	$79.44
$85,000	$8.16	$9.61	$11.82	$13.35	$14.79	$20.74	$31.03	$55.42	$84.41
$90,000	$8.64	$10.17	$12.51	$14.13	$15.66	$21.96	$32.85	$58.68	$89.37
$95,000	$9.12	$10.74	$13.21	$14.92	$16.53	$23.18	$34.68	$61.94	$94.34
$100,000	$9.60	$11.30	$13.90	$15.70	$17.40	$24.40	$36.50	$65.20	$99.30
$105,000	$10.08	$11.87	$14.60	$16.49	$18.27	$25.62	$38.33	$68.46	$104.27
$110,000	$10.56	$12.43	$15.29	$17.27	$19.14	$26.84	$40.15	$71.72	$109.23
$115,000	$11.04	$13.00	$15.99	$18.06	$20.01	$28.06	$41.98	$74.98	$114.20
$120,000	$11.52	$13.56	$16.68	$18.84	$20.88	$29.28	$43.80	$78.24	$119.16
$125,000	$12.00	$14.13	$17.38	$19.63	$21.75	$30.50	$45.63	$81.50	$124.13
$130,000	$12.48	$14.69	$18.07	$20.41	$22.62	$31.72	$47.45	$84.76	$129.09
$135,000	$12.96	$15.26	$18.77	$21.20	$23.49	$32.94	$49.28	$88.02	$134.06
$140,000	$13.44	$15.82	$19.46	$21.98	$24.36	$34.16	$51.10	$91.28	$139.02
$145,000	$13.92	$16.39	$20.16	$22.77	$25.23	$35.38	$52.93	$94.54	$143.99
$150,000	$14.40	$16.95	$20.85	$23.55	$26.10	$36.60	$54.75	$97.80	$148.95
$155,000	$14.88	$17.52	$21.55	$24.34	$26.97	$37.82	$56.58	$101.06	$153.92
$160,000	$15.36	$18.08	$22.24	$25.12	$27.84	$39.04	$58.40	$104.32	$158.88
$165,000	$15.84	$18.65	$22.94	$25.91	$28.71	$40.26	$60.23	$107.58	$163.85
$170,000	$16.32	$19.21	$23.63	$26.69	$29.58	$41.48	$62.05	$110.84	$168.81
$175,000	$16.80	$19.78	$24.33	$27.48	$30.45	$42.70	$63.88	$114.10	$173.78
$180,000	$17.28	$20.34	$25.02	$28.26	$31.32	$43.92	$65.70	$117.36	$178.74
$185,000	$17.76	$20.91	$25.72	$29.05	$32.19	$45.14	$67.53	$120.62	$183.71
$190,000	$18.24	$21.47	$26.41	$29.83	$33.06	$46.36	$69.35	$123.88	$188.67
$195,000	$18.72	$22.04	$27.11	$30.62	$33.93	$47.58	$71.18	$127.14	$193.64
$200,000	$19.20	$22.60	$27.80	$31.40	$34.80	$48.80	$73.00	$130.40	$198.60
$205,000	$19.68	$23.17	$28.50	$32.19	$35.67	$50.02	$74.83	$133.66	$203.57
$210,000	$20.16	$23.73	$29.19	$32.97	$36.54	$51.24	$76.65	$136.92	$208.53
$215,000	$20.64	$24.30	$29.89	$33.76	$37.41	$52.46	$78.48	$140.18	$213.50
$220,000	$21.12	$24.86	$30.58	$34.54	$38.28	$53.68	$80.30	$143.44	$218.46
$225,000	$21.60	$25.43	$31.28	$35.33	$39.15	$54.90	$82.13	$146.70	$223.43

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$230,000	$22.08	$25.99	$31.97	$36.11	$40.02	$56.12	$83.95	$149.96	$228.39
$235,000	$22.56	$26.56	$32.67	$36.90	$40.89	$57.34	$85.78	$153.22	$233.36
$240,000	$23.04	$27.12	$33.36	$37.68	$41.76	$58.56	$87.60	$156.48	$238.32
$245,000	$23.52	$27.69	$34.06	$38.47	$42.63	$59.78	$89.43	$159.74	$243.29
$250,000	$24.00	$28.25	$34.75	$39.25	$43.50	$61.00	$91.25	$163.00	$248.25
Policy Election Amount									
Child(ren)									
$1,000	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20	$0.20
$5,000	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
$10,000	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00

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

Premiums for Voluntary Life Increase in five-year increments

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

†Benefit reductions apply.

Manage Your Benefits:

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

LIMITATIONS AND EXCLUSIONS:

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

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

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

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

Voluntary Life Only:

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

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

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

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

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

WillPrep Services

Special bonus for participants in voluntary life plan

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

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

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

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

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

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Long-Term Disability Benefit Summary

Group Number: 00533116

About Your Benefits:

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

What Your Benefits Cover:

	Long-Term Disability
Coverage amount	60% of salary to maximum $10000/month
Maximum payment period: Maximum length of time you can receive disability benefits.	Social Security Normal Retirement Age
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 181
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 181
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $10000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after exclusion
Survivor benefit: Additional benefit payable to your family if you die while disabled.	3 months

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

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

- **Special limitations:** Provides a 24-month benefit limit for specific conditions including mental health and substance abuse. Other conditions such as chronic fatigue are also included in this limitation. Refer to contract for details.
- **Work incentive:** Plan benefit will not be reduced for a specified amount of months so that you have part-time earnings while you remain disabled, unless the combined benefit and earnings exceed 100% of your previous earnings.

Manage Your Benefits:

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

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Long-Term Disability coverage, we pay no benefits for a disability caused or contributed to by a pre-existing condition unless the disability starts after you have been insured under this plan for a specified period of time. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.
- This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA.

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

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

GUARDIAN®

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.

GUARDIAN

Critical Illness Benefit Summary

Group Number: 00533116

About Your Benefits:

It takes a lot to beat a serious illness. Unfortunately, it can also cost a lot. When you or a family member suffers a serious illness like a stroke or heart attack, Critical Illness Insurance can help with expenses that medical insurance doesn't cover like deductibles or out of pocket costs, or services like experimental treatment. Critical Illness supplements your medical and your disability income insurance. The lump sum benefit is paid when you need it most, upon diagnosis, so you can rest assured that you will have funds to offset upcoming out of pocket costs, and that you'll have the flexibility to elect treatments with less worry about the cost. Review your options and enroll today!

What Your Benefits Cover:

	CRITICAL ILLNESS	
Benefit Amount(s)	Employee may choose a lump sum benefit of $5,000 to $50,000 in $5,000 increments.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	50%
Stroke!	100%	50%
Heart Failure##	100%	50%
Coronary Arteriosclerosis#	30%	0%
Other		
Organ Failure***	100%	50%
Kidney Failure**	100%	50%
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%	
Type 1 Diabetes	100%	
Spouse Benefit	May choose a lump sum benefit of $2,500 to $25,000 in $2,500 increments up to 50% of the employee's lump sum benefit.	
Child Benefit- children age 14 days to 26 years	25% of employee's lump sum benefit	

Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages	50% at age 70
Guarantee Issue/ Conditional Issue	We Guarantee Issue up to: Less than age 70 $10,000 For a spouse: Less than age 70 $5,000 For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue, as well as for all applicants age 70+ regardless of elected amount.**
Portability: Allows you to take your Critical Illness coverage with you if you terminate employment.	Included
Pre-Existing Condition Limitation: 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.	3 months prior, 12 months after
Cancer Vaccine Benefit	$50 per lifetime for receiving a cancer vaccine

WELLNESS BENEFIT

Employee Per Year Limit	$50
Spouse Per Year Limit	$50
Child Per Year Limit	$50

- ! 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.

Critical Illness Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Critical Illness.

Your premium will not increase as you age.

Child cost is included with employee election.

		Monthly Premiums Displayed *Election Cost Per Age Bracket*					
Benefit Amount	Issue Age	*< 30*	*30-39*	*40-49*	*50-59*	*60-69*	*70+[1]*
Employee							
$5,000	**Non-tobacco**	**$3.18**	**$4.37**	**$7.60**	**$13.11**	**$20.02**	**$37.62**
	Tobacco	$4.28	$6.37	$12.95	$25.91	$43.32	$79.22
$10,000	**Non-tobacco**	**$4.68**	**$6.92**	**$12.95**	**$23.16**	**$36.02**	**$69.72**
	Tobacco	$6.88	$10.92	$23.65	$48.76	$82.62	$152.92
$15,000	**Non-tobacco**	**$6.18**	**$9.47**	**$18.30**	**$33.21**	**$52.02**	**$101.82**
	Tobacco	$9.48	$15.47	$34.35	$71.61	$121.92	$226.62
$20,000	**Non-tobacco**	**$7.68**	**$12.02**	**$23.65**	**$43.26**	**$68.02**	**$133.92**
	Tobacco	$12.08	$20.02	$45.05	$94.46	$161.22	$300.32
$25,000	**Non-tobacco**	**$9.18**	**$14.57**	**$29.00**	**$53.31**	**$84.02**	**$166.02**
	Tobacco	$14.68	$24.57	$55.75	$117.31	$200.52	$374.02
$30,000	**Non-tobacco**	**$10.68**	**$17.12**	**$34.35**	**$63.36**	**$100.02**	**$198.12**
	Tobacco	$17.28	$29.12	$66.45	$140.16	$239.82	$447.72
$35,000	**Non-tobacco**	**$12.18**	**$19.67**	**$39.70**	**$73.41**	**$116.02**	**$230.22**
	Tobacco	$19.88	$33.67	$77.15	$163.01	$279.12	$521.42
$40,000	**Non-tobacco**	**$13.68**	**$22.22**	**$45.05**	**$83.46**	**$132.02**	**$262.32**
	Tobacco	$22.48	$38.22	$87.85	$185.86	$318.42	$595.12
$45,000	**Non-tobacco**	**$15.18**	**$24.77**	**$50.40**	**$93.51**	**$148.02**	**$294.42**
	Tobacco	$25.08	$42.77	$98.55	$208.71	$357.72	$668.82
$50,000	**Non-tobacco**	**$16.68**	**$27.32**	**$55.75**	**$103.56**	**$164.02**	**$326.52**
	Tobacco	$27.68	$47.32	$109.25	$231.56	$397.02	$742.52
Benefit Amount Up To 50% of Employee Amount to a Maximum of $25,000							
Spouse							
$2,500	**Non-tobacco**	**$1.76**	**$2.43**	**$4.26**	**$7.42**	**$11.35**	**$20.90**
	Tobacco	$2.31	$3.44	$6.93	$13.83	$23.00	$41.70
$5,000	**Non-tobacco**	**$2.51**	**$3.71**	**$6.93**	**$12.45**	**$19.35**	**$36.95**
	Tobacco	$3.61	$5.71	$12.28	$25.25	$42.65	$78.55
$7,500	**Non-tobacco**	**$3.26**	**$4.99**	**$9.61**	**$17.47**	**$27.35**	**$53.00**
	Tobacco	$4.91	$7.99	$17.63	$36.68	$62.30	$115.40
$10,000	**Non-tobacco**	**$4.01**	**$6.26**	**$12.28**	**$22.50**	**$35.35**	**$69.05**
	Tobacco	$6.21	$10.26	$22.98	$48.10	$81.95	$152.25
$12,500	**Non-tobacco**	**$4.76**	**$7.54**	**$14.96**	**$27.52**	**$43.35**	**$85.10**
	Tobacco	$7.51	$12.54	$28.33	$59.53	$101.60	$189.10
$15,000	**Non-tobacco**	**$5.51**	**$8.81**	**$17.63**	**$32.55**	**$51.35**	**$101.15**
	Tobacco	$8.81	$14.81	$33.68	$70.95	$121.25	$225.95
$17,500	**Non-tobacco**	**$6.26**	**$10.09**	**$20.31**	**$37.57**	**$59.35**	**$117.20**
	Tobacco	$10.11	$17.09	$39.03	$82.37	$140.90	$262.80
$20,000	**Non-tobacco**	**$7.01**	**$11.36**	**$22.98**	**$42.60**	**$67.35**	**$133.25**
	Tobacco	$11.41	$19.36	$44.38	$93.80	$160.55	$299.65
$22,500	**Non-tobacco**	**$7.76**	**$12.64**	**$25.66**	**$47.62**	**$75.35**	**$149.30**
	Tobacco	$12.71	$21.64	$49.73	$105.23	$180.20	$336.50
$25,000	**Non-tobacco**	**$8.51**	**$13.91**	**$28.33**	**$52.65**	**$83.35**	**$165.35**
	Tobacco	$14.01	$23.91	$55.08	$116.65	$199.85	$373.35

†Benefit reductions may apply. See plan details.

Manage Your Benefits:

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

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 12 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.

If the plan is new (not transferred): During the exclusion period, this Critical Illness plan does not pay charges relating to a pre-existing condition. 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. A pre-existing condition includes any condition for which an employee, in a specified time period prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan documents for specific time periods. State variations may apply.

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 1) late enrollees and 2) enrollees over age 69 (not applicable in FL). This 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..

This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails. Your company has selected Guardian to provide Critical Illness coverage to eligible employees & dependents according to plan terms which have been mutually agreed upon. As an eligible employee, you can purchase this coverage at the group premium levels illustrated above.

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GUARDIAN

CENTENARY COLLEGE OF LOUISIANA

Group Number: 00533116

Accident Benefit Summary

	ACCIDENT
COVERAGE - DETAILS	
Your Monthly premium	$18.23
You and Spouse	$31.45
You and Child(ren)	$31.43
You, Spouse and Child(ren)	$44.65
Accident Coverage Type	Off Job
ACCIDENTAL DEATH AND DISMEMBERMENT	
Benefit Amount(s)	Employee $25,000 Spouse $25,000 Child $5,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: $10,000 & Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500
HOSPITAL CONFINEMENT SICKNESS BENEFIT - Benefit is paid if you are admitted to the hospital due to sickness.	
Employee	$100 per day, up to 20 days after a 3 day elimination period.
Spouse	$100 per day, up to 20 days after a 3 day elimination period.
Child	$100 per day, up to 20 days after a 3 day elimination period.
Hospital Confinement Sickness Pre-Existing Conditions Limitation - 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 month look back period, 12 month exclusion period.
WELLNESS BENEFIT - Per Year Limit	$50
Child(ren) Age Limits	Children age birth to 26 years
FEATURES	
Accident Emergency Room Treatment	$175
Accident Follow-Up Visit - Doctor	$50 up to 6 treatments
Air Ambulance	$1,000
Ambulance	$150
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

FEATURES (Cont.)	
Burns (2nd Degree/3rd Degree)	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
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	$25 per visit up to 6 visits
Coma	$10,000
Concussions	$75
Dislocations	Schedule up to $4,400
Diagnostic Exam (Major)	$150
Emergency Dental Work	$300/Crown, $75/Extraction
Epidural pain management	$100, 2 times per accident
Eye Injury	$300
Family Care	$20/day up to 30 days
Fracture	Schedule up to $5,500
Hospital Admission	$1,000
Hospital Confinement	$225/day - up to 1 year
Hospital ICU Admission	$2,000
Hospital ICU Confinement	$450/day - up to 15 days
Initial Physician's office/Urgent Care Facility Treatment	$75
Joint Replacement (hip/knee/shoulder)	$2,500/$1,250/$1,250
Knee Cartilage	$500
Laceration	Schedule up to $400
Lodging - The hospital must be more than 50 miles from the insured's residence.	$125/day, up to 30 days for companion hotel stay
Occupational or Physical Therapy	$25/day up to 10 days
Prosthetic Device/Artificial Limb	1: $500 2 or more: $1,000
Rehabilitation Unit Confinement	$150/day up to 15 days
Ruptured Disc With Surgical Repair	$500
Surgery	Schedule up to $1,250 Hernia: $150
Surgery - Exploratory or Arthroscopic	$250
Tendon/Ligament/Rotator Cuff	1: $500 2 or more: $1,000
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$500, 3 times per accident
X - Ray	$30

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passanger 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 Accomodation** – 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.

UNDERSTANDING YOUR BENEFITS (Cont.):

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

Manage Your Benefits:

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

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.

This plan will not pay benefits for any injury caused by or related to: declared or undeclared war, act of war or armed aggression; taking part in a riot or civil disorder; or commission of, or attempt to commit a felony; intentionally self inflicted injury, while sane or insane; suicide, while sane or insane. The covered person being legally intoxicated. Treatment rendered or hospital confinement outside the United States or Canada. Travel of flight in any kind of aircraft including any aircraft owned by or for the employer 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.

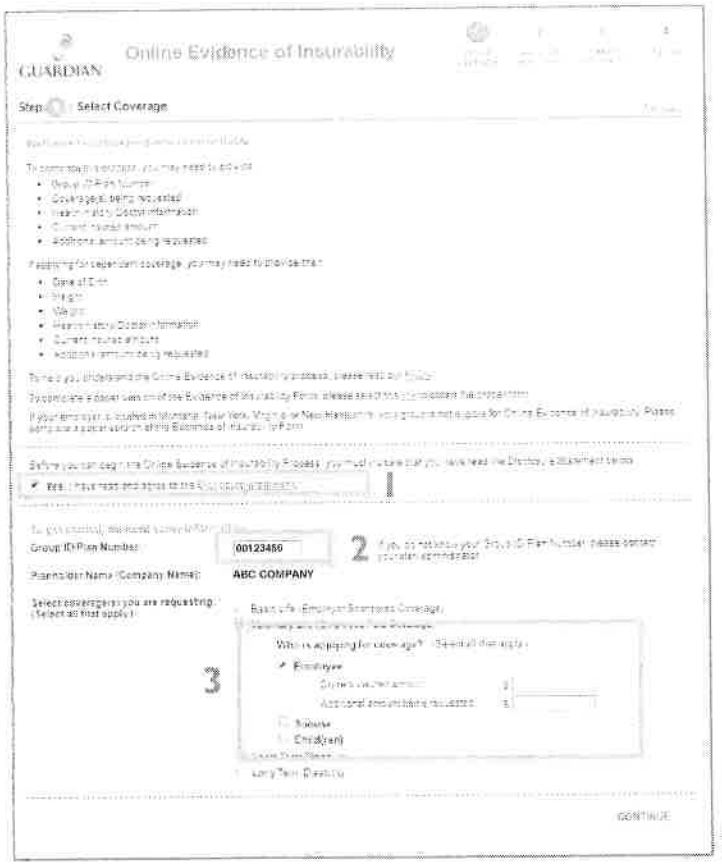
Riding in or driving any motor-driven vehicle in a race, stunt show or speed test. Participation in hang gliding, bungee jumping, sailgliding, parasailing, parakiting, ballooning, parachuting, and/or skydiving. Injuries to a dependent child received during the birth. An accident that occurred before the covered person is covered by this plan. Sickness, disease, mental infirmity or medical or surgical treatment.

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.

2017-44837 (08/19)

ONLINE EVIDENCE OF INSURABILITY

Go to www.guardiananytime.com/eoi



1. Click "Yes, I have read and agree to the Disclosure Statement."

   If your employer is located in a state where online EOI is not available, please download the EOI form from GuardianAnytime

2. Enter Group ID shown on your enrollment materials and click "Enter"

3. Select the coverages you are applying for and fill in your current and new election amounts

HELPFUL TIP: Enter "0" for current amount if this is a new election or if this is a request to increase your short term disability or long term disability coverage.

Click "Continue".

ON THE FOLLOWING SCREEN, YOU WILL:

- Input your personal information
- Answer the health questions
- Review your answers, electronically provide your signature and click "Submit" to receive confirmation (PDF)
- Guardian will soon contact you directly regarding your application.

GUARDIAN®

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004-4025
www.guardiananytime.com

ADDITIONAL NOTES: Applicable to coverage requiring full Evidence of Insurability (not applicable to conditional issue amounts)
Electronic EOI is not available in the following states: New York, New Hampshire, Virginia and Montana Electronic EOI is available using most internet browsers.

WorkLifeMatters

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

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

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

WorkLifeMatters can offer help with:

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

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

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

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

Working Smarter
- Career development
- Effective managing
- Relocation

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

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

Please print clearly and mark carefully.

Employer Name: **CENTENARY COLLEGE OF LOUISIANA**	Group Plan Number: **00533116**	Benefits Effective:_____

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

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

About You:

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

About Your Job:

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

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

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Oct 31, 2017

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

Drop Coverage:

❑ Drop Employee ❑ Drop Dependents

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

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Dental	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Vision	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Basic Life	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Voluntary Life	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Critical Illness			
❑ Accident	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Long Term Disability			

Loss Of Other Coverage:

I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to:

❑ Termination of Employment: _____-_____-_____

❑ Divorce _____-_____-_____

❑ Death of Spouse _____-_____-_____

❑ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ❑ Dental ❑ Vision

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

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

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

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
PPO	❑	❑	❑	❑

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

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

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

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature - Designer	❑ $8.45	❑ $16.90	❑ $18.24	❑ $26.52

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

- ❑ I am covered under another Vision plan
- ❑ My spouse is covered under another Vision plan
- ❑ My dependents are covered under another Vision plan

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

Policy Amount	Spouse	Child/Dependent
Employee Only ☑ 100% of your annual salary to a maximum of $250,000 The Guarantee Issue Amount is $250,000.	☑ $5,000 ***The amount may not be more than 50% of the employee amount***	☑ $2,000 ***The amount may not be more than 10% of the employee amount***

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.

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***				
❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000	❑ $60,000	❑ $70,000
❑ $80,000	❑ $90,000	❑ $100,000	❑ $110,000	❑ $120,000	❑ **$130,000***
❑ $140,000	❑ $150,000	❑ $160,000	❑ $170,000	❑ $180,000	❑ $190,000
❑ $200,000	❑ $210,000	❑ $220,000	❑ **$230,000****	❑ $240,000	❑ $250,000
❑ $260,000	❑ $270,000	❑ $280,000	❑ $290,000	❑ $300,000	❑ $310,000
❑ $320,000	❑ $330,000	❑ $340,000	❑ $350,000	❑ $360,000	❑ $370,000
❑ $380,000	❑ $390,000	❑ $400,000	❑ $410,000	❑ $420,000	❑ $430,000
❑ $440,000	❑ $450,000	❑ $460,000	❑ $470,000	❑ $480,000	❑ $490,000
❑ $500,000					

*Guarantee Issue Amount. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected. **Guarantee Issue Amount plus Additional Amount. An Evidence of Insurability form must be completed if any amount above the Guarantee Issue Amount plus Additional Amount is elected. The Guarantee Issue with Additional Amount is $230,000**.

❑ I do not want this coverage

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

***Add* Voluntary Life for Spouse**

Policy Amount

❑ $5,000	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000
❑ $35,000	❑ $40,000	❑ $45,000	❑ **$50,000***	❑ $55,000	❑ $60,000
❑ $65,000	❑ $70,000	❑ **$75,000****	❑ $80,000	❑ $85,000	❑ $90,000
❑ $95,000	❑ $100,000	❑ $105,000	❑ $110,000	❑ $115,000	❑ $120,000
❑ $125,000	❑ $130,000	❑ $135,000	❑ $140,000	❑ $145,000	❑ $150,000
❑ $155,000	❑ $160,000	❑ $165,000	❑ $170,000	❑ $175,000	❑ $180,000
❑ $185,000	❑ $190,000	❑ $195,000	❑ $200,000	❑ $205,000	❑ $210,000
❑ $215,000	❑ $220,000	❑ $225,000	❑ $230,000	❑ $235,000	❑ $240,000
❑ $245,000	❑ $250,000				

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

****The amount may not be more than 50% of the employee amount for Voluntary Life.***

❑ I do not want this coverage

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

Policy Amount

❑ $1,000 ❑ $5,000 ❑ **$10,000***

**Guarantee Issue Amount*

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

❑ I do not want this coverage

Important Notes:

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

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

Primary Beneficiaries:

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

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

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

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

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

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

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

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

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

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

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

Long-Term Disability (LTD) Coverage:

Monthly Benefit

☑ 60% of salary to a maximum of $10,000

Guardian Group Plan Number: **00533116** Please print employee name:

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

Benefit reductions apply. Please see plan administrator.

Employee
Insurance Amount:
❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000 ❑ $25,000 ❑ $30,000
❑ $35,000 ❑ $40,000 ❑ $45,000 ❑ $50,000

❑ I do not want this coverage.

Spouse
Insurance Amount: Up to 50% of the employee's amount to a maximum of $25,000

❑ $2,500 ❑ $5,000 ❑ $7,500 ❑ $10,000 ❑ $12,500 ❑ $15,000 ❑ $17,500
❑ $20,000 ❑ $22,500 ❑ $25,000

❑ 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

If you or your dependent spouse elect Critical Illness Coverage and elect an amount above the Guaranteed Issue amount, you must answer the following health questions.

1. Has any proposed insured been diagnosed with or treated by a medical professional for any of the following conditions: cancer, carcinoma in situ,malignant melanoma, tumor (benign or malignant), Barrett's esophagus, Crohn's disease, ulcerative colitis, blood disorder (other than AIDS or HIV), any chronic or progressive disease of kidneys, liver (including hepatitis), lungs, including emphysema and COPD, pancreas or bone marrow? Or, been advised to have an organ transplant, including bone marrow or stem cell transplant?

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

2. Has any proposed insured been diagnosed with or treated by a medical professional for heart attack, heart disease or coronary artery disease, stroke or transient ischemic attack (TIA), or been advised to have bypass surgery, stent insertions or treatment for coronary arteries?

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

3. Has any proposed insured been diagnosed with or treated by a medical professional for uncontrolled blood pressure (requiring a change in medication or dosage in the past 6 months or been diagnosed with or treated for diabetes (except if present only in pregnancy)?

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

4. Has any proposed insured been diagnosed with or treated by a medical professional for AIDS (acquired immune deficiency syndrome), AIDS-Related Complex or tested positive for HIV (human immunodeficiency virus)?

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

IMPORTANT NOTES:

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

Accident Coverage You must be enrolled to cover your dependents.

Your Monthly premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
	❑ $18.23	❑ $31.45	❑ $31.43	❑ $44.65

❑ I do not want this coverage.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.

NOTICE: This coverage under the policy may only be issued if you have minimum essential coverage within the meaning of section 500A(f) of the Internal Revenue Code.

Health History

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

Voluntary Life

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

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

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

Signature

- An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision 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 with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

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

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

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

Fraud Warning Statements

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

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

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

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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

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

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

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

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

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

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

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

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

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

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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

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

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.