
Group Number: 00568678

CHESTERFIELD HOLDING COMPANY

ALL 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

- Critical Illness
- Accident

Welcome

Dear CHESTERFIELD HOLDING COMPANY Employee,

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

With Guardian® coverage you get:

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

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

Guardian

GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America®. Insurance products are underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

2018-71635 (12/20)

Critical Illness Benefit Summary
Group Number: 00568678

A Critical Illness insurance plan through Guardian provides:

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

About Your Benefits:
CRITICAL ILLNESS
Benefit Amount(s)

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

CONDITIONS
Cancer
1st OCCURRENCE
2nd OCCURRENCE

Invasive Cancer

100%

0%

Carcinoma In Situ

30%

0%

Benign Brain Tumor

75%

0%

Skin Cancer

\$250 per lifetime

Not Covered

Vascular

Heart Attack

100%

0%

Stroke

100%

0%

Heart Failure

100%

0%

Coronary Arteriosclerosis

30%

0%

Other

Organ Failure

100%

0%

Kidney Failure

100%

0%

ADDITIONAL CONDITIONS
1st OCCURRENCE ONLY

Addison's Disease

30%

ALS (Lou Gehrig's Disease)

100%

Alzheimer's Disease

50%

Coma

100%

Huntington's Disease

30%

Loss of Hearing

100%

Loss of Sight

100%

Loss of Speech

100%

Multiple Sclerosis

30%

Parkinson's Disease

100%

Permanent Paralysis

50% for 1 limb, 100% for 2 limbs

Severe Burns

100%

Spouse Benefit

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

Child Benefit- children age Birth to 26 years

50% of employee's lump sum benefit

Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages

50% at age 70

CRITICAL ILLNESS

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.

We Guarantee Issue up to:
Less than age 70 \$20,000

For a spouse:
Less than age 70 \$20,000

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.

12 months prior, 12 months after

WELLNESS BENEFIT

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

Condition Definitions

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

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.

Spouse coverage premium is based on Employee age

Child cost is included with employee election.

Semi-monthly Premiums Displayed
Election Cost Per Age Bracket

Benefit Amount		Issue Age	< 30	30-39	40-49	50-59	60-69	70+ [†]
Employee								
\$10,000	Non-tobacco		\$2.90	\$3.90	\$7.00	\$12.25	\$18.90	\$38.65
	Tobacco		\$3.55	\$5.20	\$10.55	\$21.25	\$35.70	\$67.60
\$20,000	Non-tobacco		\$5.80	\$7.80	\$14.00	\$24.50	\$37.80	\$77.30
	Tobacco		\$7.10	\$10.40	\$21.10	\$42.50	\$71.40	\$135.20
Benefit Amount Up To 100% of Employee Amount to a Maximum of \$20,000								
Spouse								
\$10,000	Non-tobacco		\$2.90	\$3.90	\$7.00	\$12.25	\$18.90	\$38.65
	Tobacco		\$3.55	\$5.20	\$10.55	\$21.25	\$35.70	\$67.60
\$20,000	Non-tobacco		\$5.80	\$7.80	\$14.00	\$24.50	\$37.80	\$77.30
	Tobacco		\$7.10	\$10.40	\$21.10	\$42.50	\$71.40	\$135.20

[†]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.

This policy will not pay for a diagnosis of a listed critical illness that is made before the insured's Critical Illness effective date with Guardian.

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

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

Contract # GP-I-CI-I4

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

Group Number: 00568678
Accident Benefit Summary
Accident insurance through Guardian provides you:

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

About Your Benefits:

ACCIDENT	
COVERAGE - DETAILS	
Your Semi-monthly premium	\$7.60
You and Spouse	\$12.33
You and Child(ren)	\$12.30
You, Spouse and Child(ren)	\$17.03
Accident Coverage Type	On and Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment.	Included
ACCIDENTAL DEATH AND DISMEMBERMENT	
Benefit Amount(s)	Employee \$42,000 Spouse \$42,000 Child \$21,000
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
Child(ren) Age Limits	Children age birth to 26 years
RAINY DAY FUND	Benefit Amount: \$400 Rollover Maximum: \$200 Fund Maximum: \$800
FEATURES	
Air Ambulance	\$1,000
Ambulance	\$200
Blood/Plasma/Platelets	\$300
Burns (2nd Degree/3rd Degree)	9 sq inches To 18 sq inches: \$0/\$2,000 18 sq inches To 35 sq inches: \$1,000/\$4,000 Over 35 sq inches: \$3,000/\$12,000
Burns - Skin Graft	50% of burn benefit
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child, age 18 years or younger, is participating in an organized sport that is governed by an organization and requires formal registration to participate.	25% increase to child benefits

Benefit information illustrated within this material reflects the plan covered by Guardian as of 10/16/2020

ALL ELIGIBLE EMPLOYEES Benefit Summary

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

FEATURES (Cont.)

Chiropractic Visits	\$50/visit, up to 6 visits
Coma	\$10,000
Concussion Baseline Study	\$25
Concussions	\$200
Diagnostic Exam (Major)	\$200
Dislocations	Schedule up to \$5,000
Doctor Follow-Up Visits	\$50, up to 6 treatments
Emergency Dental Work	\$300/Crown, \$75/Extraction
Emergency Room Treatment	\$200
Epidural Anesthesia Pain Management	\$100, 2 times per accident
Eye Injury	\$300
Family Care—Benefit is payable for each child attending a Child Care center while the insured is confined to a hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident.	\$20/day, up to 30 days
Fractures	Schedule up to \$6,000
Gun Shot Wound	\$750
Hospital Admission	\$1,000
Hospital Confinement	\$250/day - up to 1 year
Hospital ICU Admission	\$2,000
Hospital ICU Confinement	\$500/day - up to 15 days
Initial Dr. Office/Urgent Care Facility Treatment	\$100
Joint Replacement (Hip/Knee/Shoulder)	\$2,500/\$1,250/\$1,250
Knee Cartilage	\$500
Laceration	Schedule up to \$400
Lodging - The hospital stay must be more than 50 miles from the insured's residence.	\$125/day, up to 30 days for companion hotel stay
Medical Appliance—Wheelchair, motorized scooter, leg or back brace, cane, crutches, walker, walking boot that extends above the ankle or brace for the neck.	Schedule up to \$500
Outpatient Therapies	\$35/day, up to 10 days
Post-Traumatic Stress Disorder	\$400
Prosthetic Device/Artificial Limb	1: \$500 2 or more: \$1,000
Rehabilitation Unit Confinement	\$100/day, up to 15 days
Ruptured Disc With Surgical Repair	\$500
Surgery (Cranial, Open Abdominal, Thoracic, Hernia) Max	Schedule up to \$1,250 Hernia: \$250
Surgery (Exploratory or Arthroscopic)	\$400
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.	\$0.50 per mile, limited to \$500/round trip, up to 3 times per accident
Traumatic Brain Injury — A nondegenerative, noncongenital Injury to the brain from an external nonbiological force, requiring Hospital Confinement for 48 hours or more and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms.	\$4,000
X - Ray	\$40

UNDERSTANDING YOUR BENEFITS:

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

UNDERSTANDING YOUR BENEFITS (Cont.):

- **Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.
- **Rainy Day Fund** – Can pay benefits when a claimant has exhausted a frequency limitation that applies to a particular benefit. Rainy Day Fund will apply to the following benefits Air Ambulance, Ambulance, Blood/Plasma/Platelets, Chiropractic visits, Diagnostic Exam (Major), Doctor Follow-Up visits, Emergency Dental Work, Epidural Anesthesia Pain Management, Eye Injury, Family Care, Fractures, Gun Shot Wound, Hospital Confinement, Hospital ICU Confinement, Joint Replacement, Knee Cartilage, Lodging, Outpatient Therapies, Rehabilitation Unit Confinement, Ruptured Disc with Surgical Repair, Surgery (Cranial, Open Abdominal, Thoracic, Hernia), Surgery (Exploratory and Arthroscopic), Transportation and X-Ray, if they are included on your plan.

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

Manage Your Benefits:

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

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF ACCIDENT LIMITATIONS AND EXCLUSIONS:

Employees must be working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

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

This proposal is hedged subject to satisfactory financial evaluation.

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

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

Contract # GP-I-ACC-I8

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.

Welcome to the College Tuition Benefits Rewards program! Your Plan Sponsor has worked with Guardian to make College Tuition Benefit services available to eligible participants enrolling in the following coverage/option(s):

Coverage	Option
Critical Illness	
Accident	Option I: Gold

Register Today!

You can now create your Rewards account and start accumulating your Tuition Rewards that can be used to pay up to one year's tuition at over 380 private colleges and universities across the nation. In 2016, over \$60 million in College Tuition Benefit Rewards were submitted by high school seniors. **Here is how it works:**

- Annual enrollment in this plan earns you 2,000 Tuition Rewards (1 Reward = \$1 in tuition reduction at a network of Private Colleges and Universities) for each line of Guardian coverage (up to four lines).
- Guardian Dental participants receive a bonus after year four.
- These rewards are yours for your lifetime and can be given to children, grandchildren, nieces, nephews and godchildren.

The Tuition Rewards program is provided by College Tuition Benefit. The Guardian Life Insurance Company of America (Guardian) does not provide any services related to this program. College Tuition Benefit is not a subsidiary or an affiliate of Guardian.

Print and cut out ID Card

College Tuition Benefits Rewards- ID Card	
<p>Register@ www.Guardian.CollegeTuitionBenefit.com</p> <p>User ID: Is Your Guardian Group Plan Number that can be found on your benefit booklet Password: Guardian</p>	<p>The College Tuition Benefit 435 Devon Park Drive Building 400, Suite 410 Wayne, PA 19087 Phone: (215) 839-0119 Fax: (215) 392-3255</p>

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

Please print clearly and mark carefully.

Employer Name: CHESTERFIELD HOLDING COMPANY	Group Plan Number: 00568678	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Re-Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change <input type="checkbox"/> Increase Amount <input type="checkbox"/> Family Status Change		

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

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

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.

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

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

<u>Drop Coverage:</u> <input type="checkbox"/> Drop Employee <input type="checkbox"/> Drop Dependents The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: ____ - ____ - ____ <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement Last Day Worked: ____ - ____ - ____ <input type="checkbox"/> Other Event: _____ Date of Event: ____ - ____ - ____	<u>Coverage Being Dropped:</u> <input type="checkbox"/> Critical Illness <input type="checkbox"/> Accident <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)
I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____ (additional information may be required)	

Critical Illness Coverage: You must be enrolled to cover your dependents <i>Benefit reductions apply. Please see plan administrator.</i> Employee Insurance Amount: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> I do not want this coverage.
Spouse Insurance Amount: Up to 100% of the employee's amount to a maximum of \$20,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> I do not want this coverage.
Dependent/Child(ren) Insurance Amount: <input type="checkbox"/> 50% of the employee's amount <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> 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 Semi-monthly premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
	<input type="checkbox"/> \$7.60	<input type="checkbox"/> \$12.33	<input type="checkbox"/> \$12.30	<input type="checkbox"/> \$17.03
<input type="checkbox"/> I do not want this coverage.				

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

Primary Beneficiaries:

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

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

Phone: () - _____ Relationship to Employee: _____

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

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

Phone: () - _____ Relationship to Employee: _____

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

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

Phone: () - _____ Relationship to Employee: _____

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

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

Signature

- 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.
- 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 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.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.