



LYON COUNTY NEVADA
ALL OTHER ELIGIBLE EMPLOYEES
Group Number: 00458586



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

Welcome to Workplace benefits

Everyone deserves a Guardian

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

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

Know your benefits

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

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

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

Your coverage options



Dental insurance

Taking care of teeth and overall health



Life insurance

Protecting your family's financial future



Short term disability insurance

Coverage if you're temporarily unable to work



Critical illness insurance

Taking care of the expenses if you're critically ill



Accident insurance

Helping you cover expenses after an accident



Cancer insurance

Financial support after a cancer diagnosis

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Watch our video
Learn how dental insurance can protect your long-term health.

Dental insurance

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

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

Who is it for?

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

What does it cover?

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

Why should I consider it?

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



Staying healthy

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

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

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

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

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

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

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

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



Your dental coverage

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

Your Dental Plan	PPO	
Your Network is	DentalGuard Preferred	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$75
Family limit	3 per family	
Waived for	Preventive	None
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	80%
Basic Care	80%	60%
Major Care	50%	40%
Orthodontia	50%	50%
Annual Maximum Benefit	\$1500	\$1000
	Combined In-Network and Out-of-Network maximum of \$1000 with an additional \$500 of benefit In-Network	
Maximum Rollover	Yes	
Rollover Threshold	\$500	
Rollover Amount	\$250	
Rollover In-network Amount	\$350	
Rollover Account Limit	\$1000	
Lifetime Orthodontia Maximum	\$1000	
Dependent Age Limits	26	



Your dental coverage

A Sample of Services Covered by Your Plan:

		PPO	
		<i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	80%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	100%	80%
	Limits:	Under Age 14	
	Oral Exams	100%	80%
	X-rays	100%	80%
		X-rays other than bitewings in Basic 80%	
Basic Care	Fillings‡	80%	60%
Major Care	Anesthesia*	50%	40%
	Bridges and Dentures	50%	40%
	Dental Implants	50%	40%
	Inlays, Onlays, Veneers**	50%	40%
	Perio Surgery	50%	40%
	Periodontal Maintenance	50%	40%
	Frequency:	Once Every 6 Months	
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	40%
	Root Canal	50%	40%
	Scaling & Root Planing (per quadrant)	50%	40%
	Simple Extractions	50%	40%
Single Crowns	50%	40%	
Surgical Extractions	50%	40%	
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 filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.



Your dental coverage

Manage Your Benefits:

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

Find A Dentist:

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

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00458586

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

EXCLUSIONS AND LIMITATIONS

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

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

Oral Health Rewards Program

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

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

How maximum rollover works*

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

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



Automatic rollover

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

* This example has been created for illustrative purposes only.

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

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Information provided in this communication is for informational purposes only. Dental Policy Form No. GP-1-DEN-16. GUARDIAN® is a registered service mark of The Guardian Life Insurance Company of America © Copyright 2023 The Guardian Life Insurance Company of America.

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

Life insurance

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

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

Who is it for?

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

What does it cover?

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

Why should I consider it?

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

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

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

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



Preparing and planning

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

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

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

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

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

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

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

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

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



Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides \$10,000 Basic Term Life coverage for all full time employees.	Choice of 26 employer-specified amounts, from \$10,000 to \$250,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage.	Not available
Spouse/Domestic Partner Benefit	Your spouse/domestic partner is eligible for coverage in the amount of \$10,000.	\$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 \$10,000. See enrollment form for details.	Your dependent children age 14 days to 26 years. \$1,000 increments to a maximum of \$10,000. Subject to state limits. See Cost Illustration page for details.



Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
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 \$10,000 per employee	We Guarantee Issue coverage up to: Employee Less than age 65 \$150,000, 65-69 \$10,000, 70+ \$0. Spouse Less than age 65 \$25,000, 65-69 \$5,000, 70+ \$0. 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. The Additional amount is available for ages Less than age 65
Premiums	Partially funded by your employer; see premium details on your enrollment form	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions, 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.	No	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	No	35% at age 65, 50% at age 70

Subject to coverage limits

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

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

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style.

Employee	Monthly premiums displayed.								
	Policy Election Cost Per Age Bracket								
Policy Election Amount	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
\$10,000	\$.86	\$.92	\$1.29	\$1.99	\$3.14	\$4.72	\$7.81	\$12.60	\$19.44
\$20,000	\$1.72	\$1.84	\$2.58	\$3.98	\$6.28	\$9.44	\$15.62	\$25.20	\$38.88
\$25,000	\$2.15	\$2.30	\$3.23	\$4.98	\$7.85	\$11.80	\$19.53	\$31.50	\$48.60
\$30,000	\$2.58	\$2.76	\$3.87	\$5.97	\$9.42	\$14.16	\$23.43	\$37.80	\$58.32
\$40,000	\$3.44	\$3.68	\$5.16	\$7.96	\$12.56	\$18.88	\$31.24	\$50.40	\$77.76
\$50,000	\$4.30	\$4.60	\$6.45	\$9.95	\$15.70	\$23.60	\$39.05	\$63.00	\$97.20
\$60,000	\$5.16	\$5.52	\$7.74	\$11.94	\$18.84	\$28.32	\$46.86	\$75.60	\$116.64
\$70,000	\$6.02	\$6.44	\$9.03	\$13.93	\$21.98	\$33.04	\$54.67	\$88.20	\$136.08
\$80,000	\$6.88	\$7.36	\$10.32	\$15.92	\$25.12	\$37.76	\$62.48	\$100.80	\$155.52
\$90,000	\$7.74	\$8.28	\$11.61	\$17.91	\$28.26	\$42.48	\$70.29	\$113.40	\$174.96
\$100,000	\$8.60	\$9.20	\$12.90	\$19.90	\$31.40	\$47.20	\$78.10	\$126.00	\$194.40
\$110,000	\$9.46	\$10.12	\$14.19	\$21.89	\$34.54	\$51.92	\$85.91	\$138.60	\$213.84
\$120,000	\$10.32	\$11.04	\$15.48	\$23.88	\$37.68	\$56.64	\$93.72	\$151.20	\$233.28
\$130,000	\$11.18	\$11.96	\$16.77	\$25.87	\$40.82	\$61.36	\$101.53	\$163.80	\$252.72
\$140,000	\$12.04	\$12.88	\$18.06	\$27.86	\$43.96	\$66.08	\$109.34	\$176.40	\$272.16
\$150,000	\$12.90	\$13.80	\$19.35	\$29.85	\$47.10	\$70.80	\$117.15	\$189.00	\$291.60
\$160,000	\$13.76	\$14.72	\$20.64	\$31.84	\$50.24	\$75.52	\$124.96	\$201.60	\$311.04
\$170,000	\$14.62	\$15.64	\$21.93	\$33.83	\$53.38	\$80.24	\$132.77	\$214.20	\$330.48
\$180,000	\$15.48	\$16.56	\$23.22	\$35.82	\$56.52	\$84.96	\$140.58	\$226.80	\$349.92
\$190,000	\$16.34	\$17.48	\$24.51	\$37.81	\$59.66	\$89.68	\$148.39	\$239.40	\$369.36
\$200,000	\$17.20	\$18.40	\$25.80	\$39.80	\$62.80	\$94.40	\$156.20	\$252.00	\$388.80
\$210,000	\$18.06	\$19.32	\$27.09	\$41.79	\$65.94	\$99.12	\$164.01	\$264.60	\$408.24
\$220,000	\$18.92	\$20.24	\$28.38	\$43.78	\$69.08	\$103.84	\$171.82	\$277.20	\$427.68
\$230,000	\$19.78	\$21.16	\$29.67	\$45.77	\$72.22	\$108.56	\$179.63	\$289.80	\$447.12
\$240,000	\$20.64	\$22.08	\$30.96	\$47.76	\$75.36	\$113.28	\$187.44	\$302.40	\$466.56
\$250,000	\$21.50	\$23.00	\$32.25	\$49.75	\$78.50	\$118.00	\$195.25	\$315.00	\$486.00
Spouse/DP	Policy Election Amount								
\$25,000	\$2.15	\$2.30	\$3.23	\$4.98	\$7.85	\$11.80	\$19.53	\$31.50	\$48.60

Voluntary Life Cost Illustration *continued*

	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
\$30,000	\$2.58	\$2.76	\$3.87	\$5.97	\$9.42	\$14.16	\$23.43	\$37.80	\$58.32
\$35,000	\$3.01	\$3.22	\$4.52	\$6.97	\$10.99	\$16.52	\$27.34	\$44.10	\$68.04
\$40,000	\$3.44	\$3.68	\$5.16	\$7.96	\$12.56	\$18.88	\$31.24	\$50.40	\$77.76
\$45,000	\$3.87	\$4.14	\$5.81	\$8.96	\$14.13	\$21.24	\$35.15	\$56.70	\$87.48
\$50,000	\$4.30	\$4.60	\$6.45	\$9.95	\$15.70	\$23.60	\$39.05	\$63.00	\$97.20
\$55,000	\$4.73	\$5.06	\$7.10	\$10.95	\$17.27	\$25.96	\$42.96	\$69.30	\$106.92
\$60,000	\$5.16	\$5.52	\$7.74	\$11.94	\$18.84	\$28.32	\$46.86	\$75.60	\$116.64
\$65,000	\$5.59	\$5.98	\$8.39	\$12.94	\$20.41	\$30.68	\$50.77	\$81.90	\$126.36
\$70,000	\$6.02	\$6.44	\$9.03	\$13.93	\$21.98	\$33.04	\$54.67	\$88.20	\$136.08
\$75,000	\$6.45	\$6.90	\$9.68	\$14.93	\$23.55	\$35.40	\$58.58	\$94.50	\$145.80
\$80,000	\$6.88	\$7.36	\$10.32	\$15.92	\$25.12	\$37.76	\$62.48	\$100.80	\$155.52
\$85,000	\$7.31	\$7.82	\$10.97	\$16.92	\$26.69	\$40.12	\$66.39	\$107.10	\$165.24
\$90,000	\$7.74	\$8.28	\$11.61	\$17.91	\$28.26	\$42.48	\$70.29	\$113.40	\$174.96
\$95,000	\$8.17	\$8.74	\$12.26	\$18.91	\$29.83	\$44.84	\$74.20	\$119.70	\$184.68
\$100,000	\$8.60	\$9.20	\$12.90	\$19.90	\$31.40	\$47.20	\$78.10	\$126.00	\$194.40
\$105,000	\$9.03	\$9.66	\$13.55	\$20.90	\$32.97	\$49.56	\$82.01	\$132.30	\$204.12
\$110,000	\$9.46	\$10.12	\$14.19	\$21.89	\$34.54	\$51.92	\$85.91	\$138.60	\$213.84
\$115,000	\$9.89	\$10.58	\$14.84	\$22.89	\$36.11	\$54.28	\$89.82	\$144.90	\$223.56
\$120,000	\$10.32	\$11.04	\$15.48	\$23.88	\$37.68	\$56.64	\$93.72	\$151.20	\$233.28
\$125,000	\$10.75	\$11.50	\$16.13	\$24.88	\$39.25	\$59.00	\$97.63	\$157.50	\$243.00
\$130,000	\$11.18	\$11.96	\$16.77	\$25.87	\$40.82	\$61.36	\$101.53	\$163.80	\$252.72
\$135,000	\$11.61	\$12.42	\$17.42	\$26.87	\$42.39	\$63.72	\$105.44	\$170.10	\$262.44
\$140,000	\$12.04	\$12.88	\$18.06	\$27.86	\$43.96	\$66.08	\$109.34	\$176.40	\$272.16
\$145,000	\$12.47	\$13.34	\$18.71	\$28.86	\$45.53	\$68.44	\$113.25	\$182.70	\$281.88
\$150,000	\$12.90	\$13.80	\$19.35	\$29.85	\$47.10	\$70.80	\$117.15	\$189.00	\$291.60
\$155,000	\$13.33	\$14.26	\$20.00	\$30.85	\$48.67	\$73.16	\$121.06	\$195.30	\$301.32
\$160,000	\$13.76	\$14.72	\$20.64	\$31.84	\$50.24	\$75.52	\$124.96	\$201.60	\$311.04
\$165,000	\$14.19	\$15.18	\$21.29	\$32.84	\$51.81	\$77.88	\$128.87	\$207.90	\$320.76
\$170,000	\$14.62	\$15.64	\$21.93	\$33.83	\$53.38	\$80.24	\$132.77	\$214.20	\$330.48
\$175,000	\$15.05	\$16.10	\$22.58	\$34.83	\$54.95	\$82.60	\$136.68	\$220.50	\$340.20
\$180,000	\$15.48	\$16.56	\$23.22	\$35.82	\$56.52	\$84.96	\$140.58	\$226.80	\$349.92
\$185,000	\$15.91	\$17.02	\$23.87	\$36.82	\$58.09	\$87.32	\$144.49	\$233.10	\$359.64

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LYON COUNTY NEVADA

ALL OTHER ELIGIBLE EMPLOYEES

Kit created 05/05/2025

Group number: 00458586

Voluntary Life Cost Illustration *continued*

	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69 [†]
\$190,000	\$16.34	\$17.48	\$24.51	\$37.81	\$59.66	\$89.68	\$148.39	\$239.40	\$369.36
\$195,000	\$16.77	\$17.94	\$25.16	\$38.81	\$61.23	\$92.04	\$152.30	\$245.70	\$379.08
\$200,000	\$17.20	\$18.40	\$25.80	\$39.80	\$62.80	\$94.40	\$156.20	\$252.00	\$388.80
\$205,000	\$17.63	\$18.86	\$26.45	\$40.80	\$64.37	\$96.76	\$160.11	\$258.30	\$398.52
\$210,000	\$18.06	\$19.32	\$27.09	\$41.79	\$65.94	\$99.12	\$164.01	\$264.60	\$408.24
\$215,000	\$18.49	\$19.78	\$27.74	\$42.79	\$67.51	\$101.48	\$167.92	\$270.90	\$417.96
\$220,000	\$18.92	\$20.24	\$28.38	\$43.78	\$69.08	\$103.84	\$171.82	\$277.20	\$427.68
\$225,000	\$19.35	\$20.70	\$29.03	\$44.78	\$70.65	\$106.20	\$175.73	\$283.50	\$437.40
\$230,000	\$19.78	\$21.16	\$29.67	\$45.77	\$72.22	\$108.56	\$179.63	\$289.80	\$447.12
\$235,000	\$20.21	\$21.62	\$30.32	\$46.77	\$73.79	\$110.92	\$183.54	\$296.10	\$456.84
\$240,000	\$20.64	\$22.08	\$30.96	\$47.76	\$75.36	\$113.28	\$187.44	\$302.40	\$466.56
\$245,000	\$21.07	\$22.54	\$31.61	\$48.76	\$76.93	\$115.64	\$191.35	\$308.70	\$476.28
\$250,000	\$21.50	\$23.00	\$32.25	\$49.75	\$78.50	\$118.00	\$195.25	\$315.00	\$486.00

Policy Election Amount

Child(ren)

\$1,000	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17	\$0.17
\$2,000	\$0.33	\$0.33	\$0.33	\$0.33	\$0.33	\$0.33	\$0.33	\$0.33	\$0.33
\$3,000	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50
\$4,000	\$0.67	\$0.67	\$0.67	\$0.67	\$0.67	\$0.67	\$0.67	\$0.67	\$0.67
\$5,000	\$0.84	\$0.84	\$0.84	\$0.84	\$0.84	\$0.84	\$0.84	\$0.84	\$0.84
\$6,000	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00	\$1.00
\$7,000	\$1.17	\$1.17	\$1.17	\$1.17	\$1.17	\$1.17	\$1.17	\$1.17	\$1.17
\$8,000	\$1.34	\$1.34	\$1.34	\$1.34	\$1.34	\$1.34	\$1.34	\$1.34	\$1.34
\$9,000	\$1.50	\$1.50	\$1.50	\$1.50	\$1.50	\$1.50	\$1.50	\$1.50	\$1.50
\$10,000	\$1.67	\$1.67	\$1.67	\$1.67	\$1.67	\$1.67	\$1.67	\$1.67	\$1.67

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

Premiums for Voluntary Life Increase in five-year increments

Spouse/DP coverage premium is based on Employee age.

[†]Benefit reductions apply.

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

LIMITATIONS AND EXCLUSIONS:

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

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

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

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

Voluntary Life Only:

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

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

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

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

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

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Watch our video
How short term disability insurance can supplement your income.

Short term disability insurance

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

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

Who is it for?

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

What does it cover?

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

Why should I consider it?

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

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



Replacing Income

Mike injures his back bicycling and can't work or earn a paycheck for a few months.

After a brief waiting period, his disability plan starts paying him a portion of his normal weekly salary. The Guardian policy also provides personal guidance and support, including vocational rehabilitation and outplacement services, to help him get back to his job and full pay 13 weeks later.

Thanks to Mike's disability benefits, he was able to cover his expenses while he was out - without dipping into his family's savings.

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



Your short term disability coverage

Short-Term Disability

Coverage amount	Choose weekly amount \$100, \$200, \$300, \$400, \$500, \$600, \$700, \$800, \$900 or \$1000
Maximum payment period: Maximum length of time you can receive disability benefits.	13 weeks
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 8
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 8
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 \$1000 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 2 week limitation
Premium waived if disabled: Premium will not need to be paid when you are receiving benefits.	Yes

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

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



Your short term disability coverage

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability may be required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Short-Term Disability coverage, benefits for a disability caused or contributed to by a pre-existing condition are limited, unless the disability starts after you have been insured under this plan for a specified period of time. We do not pay short term disability benefits for any job-related or on-the-job injury, or conditions for which Workers' Compensation benefits are payable.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.
- This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA, DC PFML and WA PFML.

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

Guardian's Group Short Term Disability Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage. Policy Form #GP-1-STD07-1.0, et al, GP-1-STD-15

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Watch our video
How critical illness insurance helps cover the costs of treatment.

Critical illness insurance

Critical illness insurance may help you cover expenses not covered by your health insurance.

It's a cash payment you receive if you ever experience a serious illness like cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery.

Who is it for?

Critical illness insurance is a supplemental policy for people who already have health insurance. It provides you with an additional payment to cover expenses like deductibles, treatments, and living costs.

What does it cover?

Critical illnesses include strokes, heart attacks, Parkinson's disease and cancer. Our policies can cover over 30 major illnesses, helping you stay financially stable by paying you a lump sum if you're diagnosed with one of them.

Why should I consider it?

Health coverage is becoming more expensive, with higher co-pays, premiums, and deductibles. Critical illness insurance is an affordable way to supplement and pay for additional expenses that your health insurance doesn't cover. Our policies typically provide payments for the first and second time you're diagnosed with a covered illness.

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

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



Critical costs

John is hospitalized after a heart attack, and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **\$53,000**

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

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **\$10,300**.

Total out-of-pocket amount for John (deductible + coinsurance): **\$11,800**.

John has a **\$10,000** Guardian Critical Illness policy, which covers the majority of these out-of-pocket expenses.

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



Your critical illness coverage

CRITICAL ILLNESS

Benefit Amount(s)	Employee may choose a lump sum benefit of \$5,000 to \$25,000 in \$5,000 increments.	
CONDITIONS		
Vascular	1st OCCURRENCE	2nd OCCURRENCE
Heart Attack	100%	0%
Stroke	100%	0%
Heart Failure	100%	0%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	0%
Kidney Failure	100%	0%
Spouse/Domestic Partner Benefit	May choose a lump sum benefit of \$2,500 to \$12,500 in \$2,500 increments up to 50% of the employee's lump sum benefit.	
Child Benefit- children age Birth 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	
Conditional Issue	Health questions are required for all amounts on employee and spouse.	
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	

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.



Your critical illness coverage

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.

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..

Contract # GP-1-CI-14

Guardian's Critical Illness Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Policy Form # GP-1-LAH-12R; GP-1-CI-14

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Watch our video
How accident insurance
can get you back on your feet.

Accident insurance

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

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

Who is it for?

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

What does it cover?

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

Why should I consider it?

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

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

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



Added support during recovery

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

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

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

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

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

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

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



Your accident coverage

ACCIDENT

COVERAGE - DETAILS

Accident Coverage Type	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 \$25,000 Spouse \$12,500 Child \$5,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
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

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
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



Your accident coverage

FEATURES (Cont.)

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



Your accident coverage

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, or skydiving; an accident that occurred before the covered person is covered by this plan; injuries to a dependent child received during birth; voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a covered person by a doctor, and (2) it was used as prescribed. In the case of a non-prescription drug, this Plan does not pay for any Accident resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time. Job related or on the job injuries for the employee are excluded if Accident coverage is off job only.

Contract # GP-I-AC-IC-12

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

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

IMPORTANT NOTICE –THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Policy Form # GP-1-AC-BEN-12, et al., GP-1-LAH-12R; GP-1-ACC-18



Watch our video
How cancer insurance can ease the financial burden of a cancer diagnosis.

Cancer insurance

If you're diagnosed with cancer, the last thing you need to think about is the cost. Cancer insurance helps ease the financial burden.

Every year, more and more people are diagnosed with cancer. Unfortunately, in addition to bearing the physical and emotional toll of this disease, patients are often saddled with added financial expenses.

Who is it for?

Cancer insurance is for people who want added financial protection, in addition to their regular health insurance. It comes into play if you are diagnosed with cancer—providing additional financial support to help keep the focus on your cancer treatment and recovery.

What does it cover?

Cancer insurance benefits can help you handle medical plan deductibles, co-pays and other out-of-pocket costs by providing benefits when you receive radiation or chemotherapy treatment, or are hospitalized for surgery to treat cancer. These benefits can be used for non-medical expenses such as transportation to treatment facilities, and even everyday living expenses like groceries, rent, and mortgage payments.

Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. The unexpected out-of-pocket expenses of cancer recovery, including transportation, co-pays, and deductibles, can add up fast. What's more, some of the costs you may incur during recovery are non-medical, such as covering a mortgage, childcare, and household expenses. Cancer insurance can help you pay for all of them.

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

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



Extra support

Sarah's diagnosed with kidney cancer after a screening test and decides to undergo kidney removal surgery.

Average surgical expense: **\$25,000**

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

Major Medical covers 80% of the surgical cost after the deductible is met, but Sarah's still responsible for 20%: **\$4,700**

Total out-of-pocket amount for Sarah (deductible + coinsurance): **\$6,200**

Sarah has Guardian's Cancer Advantage policy, which pays her **\$2,500** as an initial diagnosis benefit and **\$2,100** for a 7-day hospital stay.

This gives her a total of **\$4,600** to help cover a portion of her out-of-pocket amount.

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



Your cancer coverage

CANCER

COVERAGE - DETAILS

INITIAL DIAGNOSIS BENEFIT - Paid when you are diagnosed with internal invasive cancer for the first time while insured under this Plan.

Benefit Amount(s)

Employee \$2,500
Spouse \$2,500
Child \$2,500

Benefit Waiting Period - A specified period of time after your effective date during which the Initial Diagnosis benefits will not be payable.

30 Days

CANCER SCREENING

Benefit Amount

\$50; \$50 for Follow-Up screening

RADIATION THERAPY OR CHEMOTHERAPY

Benefit

Schedule amounts up to a \$4,000 benefit year maximum.

Conditional Issue - The "conditional" means the applicant (employee, spouse or child) can qualify for coverage if he/she responds "No" to the conditional medical question on the enrollment form.

You will be required to answer one medical question as a part of your enrollment form.

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.

3 month look back period, 12 month exclusion period.

Portability: Allows you to take your Cancer coverage with you if you terminate employment. Ported Cancer plan terminates at age 70.

Included

Child(ren) Age Limits

Children age birth to 26 years

FEATURES

Air Ambulance

\$1,500/trip, limit 2 trips per hospital confinement

Ambulance

\$200/trip, limit 2 trips per hospital confinement

Anesthesia

25% of surgery benefit

Anti-Nausea

\$50/day up to \$150 per month

Attending Physician

\$25/day while hospital confined. Limit 75 visits.

Blood/Plasma/Platelets

\$100/day up to \$5,000 per year

Bone Marrow/Stem Cell

Bone Marrow: \$7,500
Stem Cell: \$1,500
50% benefit for 2nd transplant. \$1,000 benefit if a donor

Experimental Treatment

\$100/day up to \$1,000/month

Extended Care Facility/Skilled Nursing care

\$100/day up to 90 days per year

Government or Charity Hospital

\$300 per day in lieu of all other benefits

Home Health Care

\$50/visit up to 30 visits per year

Hormone Therapy

\$25/treatment up to 12 treatments per year

Hospice

\$50/day up to 100 days/lifetime

Hospital Confinement

\$300/day for first 30 days; \$600/day for 31st day thereafter per confinement



Your cancer coverage

FEATURES (Cont.)

ICU Confinement	\$400/day for first 30 days; \$600/day for 31st day thereafter per confinement
Immunotherapy	\$500 per month, \$2500 lifetime max
Inpatient Special Nursing	\$100/day up to 30 days per year
Medical Imaging	\$100/image up to 2 per year
Outpatient and family member lodging - Lodging must be more than 50 miles from your home.	\$75/day, up to 90 days per year
Outpatient or Ambulatory Surgical Center	\$250/day, 3 days per procedure
Physical or Speech Therapy	\$25/visit up to 4 visits per month, \$400 lifetime max
Prosthetic	Surgically Implanted: \$2,000/device, \$4,000 lifetime max Non-Surgically: \$200/device, \$400 lifetime max
Reconstructive Surgery	Breast TRAM Flap \$2,000 Breast reconstruction \$500 Breast Symmetry \$250 Facial reconstruction \$500
Second Surgical Opinion	\$200/surgery procedure
Skin Cancer	Biopsy Only: \$100 Reconstructive Surgery: \$250 Excision of a skin cancer: \$375 Excision of a skin cancer with flap or graft: \$600
Surgical Benefit	Schedule amount up to \$4,125
Transportation/Companion Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive treatment for internal cancer.	\$0.50/mile up to \$1,000 per round trip/equal benefit for companion
Waiver of Premium - If you become disabled due to cancer that is diagnosed after the employee's effective date, and you remain disabled for 90 days, we will waive the premium due after such 90 days for as long as you remain disabled.	Included

UNDERSTANDING YOUR BENEFITS :

- Cancer** – Cancer means you have been diagnosed with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. Cancer includes carcinomas in-situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodysplastic and myeloproliferative disorders, carcinoid, leukoplakia, hyperplasia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions will not be considered cancer. Cancer must be diagnosed while insured under the Guardian cancer plan.
- Experimental Treatment** – Benefits will be paid for experimental treatment prescribed by a doctor for the purpose of destroying or changing abnormal tissue. All treatment must be NCI listed as viable experimental treatment for Internal Cancer.



Your cancer coverage

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF CANCER LIMITATIONS AND EXCLUSIONS:

Conditional Issue is one medical question as a part of the enrollment form.

This plan will not pay benefits for: Services or treatment not included in the Features. Services or treatment provided by a family member. Services or treatment rendered for hospital confinement outside the United States. Any cancer diagnosed solely outside of the United States. Services or treatment provided primarily for cosmetic purposes. Services or treatment for premalignant conditions. Services or treatment for conditions with malignant potential. Services or treatment for non-cancer sicknesses.

Cancer caused by, contributed to by, or resulting from: participating in a felony, riot or insurrection; intentionally causing a self-inflicted injury; committing or attempting to commit suicide while sane or insane; a covered person's mental or emotional disorder, alcoholism or drug addiction; engaging in any illegal activity; or serving in the armed forces or any auxiliary unit of the armed forces of any country.

If Cancer 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-1-CAN-IC-12

Guardian's Cancer Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Policy Form # GP-1-CAN-IC-12, et al, GP-1-LAH-12R

Electronic Evidence of Insurability (EOI)

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

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

Electronic EOI keeps things simple

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

Electronic EOI can be used for*:

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

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



How it works

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

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

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



Employee Assistance Program

We all need a little support every now and then.

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

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

How it can help



Consultative services are available to provide direct support and assistance



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



Access legal and financial assistance and resources – including WillPrep Services

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

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

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



How to access



Visit

worklife.uprisehealth.com



Access Code

worklife



Call

1 800 386 7055

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

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2023-158793 (7/25)

WillPrep

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

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

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

How it can help



Access simple documents including wills and power of attorney letters



Speak with consultants to discuss estate planning



Prepare your will with the assistance or support of an attorney

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

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



How to access

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



Visit

willprep.uprisehealth.com



Username

WillPrep



Password

GLIC09

For more information or support, you can reach out by phoning

1 877 433 6789.

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Our commitment to you

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

Important information



Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

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

Visit <https://www.guardiananytime.com/notice48> to read more.

No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.

Visit <https://www.guardiananytime.com/notice46> to read more.

Dental insurance



Guardian's HIPAA Notice of Privacy Practices

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

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

Short term disability insurance



Disability Offset Notice

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

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

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

Please print clearly and mark carefully.

Employer/Planholder Name: LYON COUNTY NEVADA	Group Plan Number: 00458586	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Employee/Member Dependents/Family Members <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		
<p>In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term, and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.</p>		

Class: ALL OTHER ELIGIBLE EMPLOYEES	Division: _____	Subtotal Code: _____	(Please obtain this from your Employer/Planholder)
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About You: Full Legal Name-First, MI, Last Name: What is the name you go by? (optional)	Employer/Planholder Provided Identification: _____	Social Security Number ____ - ____ - ____ Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	
Address _____	City _____	State _____	Zip _____
Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy): ____ - ____ - ____		
Phone (indicate primary): <input type="checkbox"/> Home (____) ____ - ____ <input type="checkbox"/> Work (____) ____ - ____ <input type="checkbox"/> Mobile (____) ____ - ____			
E mail Address (indicate primary) <input type="checkbox"/> Home _____ <input type="checkbox"/> Work _____			
Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of marriage/union: ____ - ____ - ____			
Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No Placement date of adopted child: ____ - ____ - ____			

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

About Your Family: Please include the names of the Dependents/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.

If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.

Spouse Address/City/State/Zip: Phone: () -	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
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CEF2022-NV

Questions? Call the Guardian Helpline (888) 600-1600

www.guardianlife.com

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

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

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

PPO	<input type="checkbox"/> Employee/Member Only	<input type="checkbox"/> Employee/Member & Spouse	<input type="checkbox"/> Employee/Member & Dependent/Child(ren)	<input type="checkbox"/> Employee/Member, Spouse & Dependent/Child(ren)
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I do not want Dental Coverage because (Check as applicable):

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

Guardian Group Plan Number: 00458586

Please print employee name:

Basic Life Coverage with Accidental Death and Dismemberment (AD&D): You must be enrolled to cover your dependents/family members. The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Policy Amount
Employee/Member Only
 \$10,000
The Guarantee Issue Amount is \$10,000.
* If Employee/Member is 65+ benefit reductions may apply which may change the GI amount. Please see enrollment materials for details.

Spouse
 \$10,000
** The amount may not be more than 50% of the Employee/Member amount*
 I do not want this coverage.

Child/Dependent
 \$10,000
**The amount may not be more than 10% of the Employee/Member amount*
 I do not want this coverage.

Employee/Member Name your beneficiaries: (Primary beneficiary percentages must total 100%)
If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records.
Primary Beneficiaries:
Name: _____ Social Security Number: _____ - _____ - _____ %
Date of Birth (mm-dd-yy): ____ - ____ - ____
Address/City/State/Zip: _____
Phone: () - _____ Relationship to Employee/Member: _____
Name: _____ Social Security Number: _____ - _____ - _____ %
Date of Birth (mm-dd-yy): ____ - ____ - ____
Address/City/State/Zip: _____
Phone: () - _____ Relationship to Employee/Member: _____
Contingent Beneficiary: _____ Social Security Number: _____ - _____ - _____
Date of Birth (mm-dd-yy): ____ - ____ - ____
Address/City/State/Zip: _____
Phone: () - _____ Relationship to Employee/Member: _____
(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer/Planholder maintains beneficiary information.)

Dependents/Family Members – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.
Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian’s ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary’s designated Custodian to manage on the minor’s behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.
Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. Yes No
If you answered “Yes”, please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:
Custodian to Minor Beneficiaries:
Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): _____
Date of Birth (mm-dd-yyyy) (if an individual): ____ - ____ - ____
Address/City/State/Zip: _____
Phone: () - _____

If this Basic Life coverage will replace your existing life insurance coverage through your current Employer/Planholder, provide the amount of the previous policy \$ _____

Important Notes:
• Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

LIFE INSURANCE *continued*

Voluntary Term Life Coverage: You must be enrolled to cover your dependents/family members. *Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Employee/Member

Policy Amount

Check one box only

- | | | | | | |
|------------------------------------|------------------------------------|------------------------------------|-------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$25,000 | <input type="checkbox"/> \$30,000 | <input type="checkbox"/> \$40,000 | <input type="checkbox"/> \$50,000 |
| <input type="checkbox"/> \$60,000 | <input type="checkbox"/> \$70,000 | <input type="checkbox"/> \$80,000 | <input type="checkbox"/> \$90,000 | <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$110,000 |
| <input type="checkbox"/> \$120,000 | <input type="checkbox"/> \$130,000 | <input type="checkbox"/> \$140,000 | <input type="checkbox"/> \$150,000* | <input type="checkbox"/> \$160,000 | <input type="checkbox"/> \$170,000 |
| <input type="checkbox"/> \$180,000 | <input type="checkbox"/> \$190,000 | <input type="checkbox"/> \$200,000 | <input type="checkbox"/> \$210,000 | <input type="checkbox"/> \$220,000 | <input type="checkbox"/> \$230,000 |

Guarantee Issue up to: Employee Less than age 65 \$150,000*, 65-69 \$10,000, 70+ \$0. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected. Additional Amount: per employee \$100,000**. The Additional amount is available for ages Less than age 65. An Evidence of Insurability form must be completed if any amount above the Guarantee Issue Amount plus Additional Amount is elected.

I do not want this coverage

Add Voluntary Life for Spouse

Policy Amount

- | | | | | | |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> \$25,000* | <input type="checkbox"/> \$30,000 | <input type="checkbox"/> \$35,000 | <input type="checkbox"/> \$40,000 | <input type="checkbox"/> \$45,000 | <input type="checkbox"/> \$50,000** |
| <input type="checkbox"/> \$55,000 | <input type="checkbox"/> \$60,000 | <input type="checkbox"/> \$65,000 | <input type="checkbox"/> \$70,000 | <input type="checkbox"/> \$75,000 | <input type="checkbox"/> \$80,000 |
| <input type="checkbox"/> \$85,000 | <input type="checkbox"/> \$90,000 | <input type="checkbox"/> \$95,000 | <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$105,000 | <input type="checkbox"/> \$110,000 |
| <input type="checkbox"/> \$115,000 | <input type="checkbox"/> \$120,000 | <input type="checkbox"/> \$125,000 | <input type="checkbox"/> \$130,000 | <input type="checkbox"/> \$135,000 | <input type="checkbox"/> \$140,000 |
| <input type="checkbox"/> \$145,000 | <input type="checkbox"/> \$150,000 | <input type="checkbox"/> \$155,000 | <input type="checkbox"/> \$160,000 | <input type="checkbox"/> \$165,000 | <input type="checkbox"/> \$170,000 |
| <input type="checkbox"/> \$175,000 | <input type="checkbox"/> \$180,000 | <input type="checkbox"/> \$185,000 | <input type="checkbox"/> \$190,000 | <input type="checkbox"/> \$195,000 | <input type="checkbox"/> \$200,000 |
| <input type="checkbox"/> \$205,000 | <input type="checkbox"/> \$210,000 | <input type="checkbox"/> \$215,000 | <input type="checkbox"/> \$220,000 | <input type="checkbox"/> \$225,000 | <input type="checkbox"/> \$230,000 |
| <input type="checkbox"/> \$235,000 | <input type="checkbox"/> \$240,000 | <input type="checkbox"/> \$245,000 | <input type="checkbox"/> \$250,000 | | |

Guarantee Issue up to: Spouse Less than age 65 \$25,000*, 65-69 \$5,000, 70+ \$0. Additional Amount: Spouse \$25,000**. The Additional amount is available for ages Less than age 65

**The amount may not be more than 100% of the employee amount for Voluntary Life.*

I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

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

**Guarantee Issue Amount*

**The amount may not be more than 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.

Guardian Group Plan Number: 00458586

Please print employee name:

LIFE INSURANCE *continued*

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

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

Primary Beneficiaries:

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

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

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

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

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

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

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

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

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

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

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

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

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

Custodian to Minor Beneficiaries:

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

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____

Short-Term Disability (STD) Coverage:

The amount of STD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Weekly Benefit

- \$100.00
- \$200.00
- \$300.00
- \$400.00
- \$500.00
- \$600.00
- \$700.00
- \$800.00
- \$900.00
- \$1,000.00

This amount may not exceed 60% of your weekly salary.

I do not want this coverage.

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

Benefit reductions apply. Please see plan administrator.

Employee/Member

Insurance Amount: \$5,000 \$10,000 \$15,000 \$20,000 \$25,000

I do not want this coverage.

Spouse

Insurance Amount: Up to 50% of the employee/member's amount to a maximum of \$12,500

\$2,500 \$5,000 \$7,500 \$10,000 \$12,500

I do not want this coverage.

Dependent/Child(ren)

Insurance Amount: 25% of the employee/member's amount

I do not want this coverage.

1. Has any proposed insured been diagnosed with or treated by a medical professional for any of the following conditions: 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/Member 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/Member 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/Member 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),or tested positive for HIV (human immunodeficiency virus)?

Employee/Member Yes No Spouse Yes No

Guardian Group Plan Number: **00458586**

Please print employee name:

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

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

Primary Beneficiaries:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Custodian to Minor Beneficiaries:

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

Date of Birth (mm-dd-yyyy) (if an individual): ____ - ____ - ____ Address/City/State/Zip: _____

Phone: () - _____

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

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

I do not want this coverage.

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

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

Primary Beneficiaries:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Custodian to Minor Beneficiaries:

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

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____

Cancer Coverage You must be enrolled to cover your dependents. Check only one box.

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

I do not want this coverage.

Complete the following question if you are enrolling for Cancer coverage. NOTE: Additional information may be required.

You must answer the following health question if you or your Dependents/Family Members elect Cancer Coverage:

- and elect an amount above the Guaranteed Issue amount
- or elect coverage outside the Group Enrollment Period as established by the Employer/Planholder
- or elect coverage age 70 or over

Has any proposed insured been treated for or diagnosed as having Cancer in any form, Acquired Immune Deficiency Syndrome (AIDS) within the last 5 years?

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.

If you indicated that any of your dependent/child(ren) have been treated or diagnosed as having any of the condition listed, please provide their names here.

Name(s): _____

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

Guardian Group Plan Number: **00458586**

Please print employee name:

In the last 6 months have you 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 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

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- LIFE ONLY: I understand that life insurance coverage for a dependent/family member, other than a newborn child, will not take effect if that dependent/family member is confined to a hospital or other health care facility, or is home confined, or is unable to perform two or more Activities of Daily Living (ADL's).
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I 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 hereto, may be guilty of committing a fraudulent insurance act as determined by a court of law, which may be 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.

SIGNATURE OF EMPLOYEE/MEMBER X _____

DATE _____

Fraud Warning Statements

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

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

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

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

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

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

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

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

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

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

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

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

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

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