GUARDIAN®

Group Number: 414474

Ellenville Regional Hospital

Class 2-Working 36+ hours

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

PLAN HIGHLIGHTS

- Dental
- Vision
- Life

Questions? Concerns?

Helpline (888) 600-1600
Call weekdays, 7:00 AM to 8:30 PM, EST.
And refer to your plan number: 414474

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GUARDIAN®

Dental Benefit Summary

Group Number: 414474

About Your Benefits:

Good oral hygiene is important, not only for looks, but for general health as well. A routine dental examination can detect many diseases including heart disease, diabetes, anemia, stomach ulcers, osteoporosis and kidney disease. Regular check ups and cleanings can save you the pain and expense of future problems. Using your dental insurance for regular dental check- ups can improve your health. Your dental insurance can also help save you money if more serious dental treatments are needed.

Option 1 or 2: With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

	Option 1: PPO		**Option 2: PPO**	
Network	DentalGuard Preferred		DentalGuard Preferred	
Your Bi-weekly premium	**$17.74**		**$21.71**	
You and spouse	$33.03		$40.43	
You and child(ren)	$40.49		$48.62	
You, spouse and child(ren)	$55.79		$67.34	
Calendar year deductible	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual	$100	$100	$100	$100
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Preventive Care (e.g. cleanings)	100%	100%	100%	100%
Basic Care (e.g. fillings)	50%	50%	80%	80%
Major Care (e.g. crowns, dentures)	50%	50%	50%	50%
Orthodontia	50%	50%	50%	50%
Annual Maximum Benefit	$1000	$1000	$1500	$1500
Maximum Rollover	Yes		Yes	
Rollover Threshold	$500		$700	
Rollover Amount	$250		$350	
Rollover In-network Amount	$350		$500	
Rollover Account Limit	$1000		$1250	
Lifetime Orthodontia Maximum	$1000		$1500	
Dependent Age Limits(Non-Student/Student)	20/26		20/26	

A Sample of Services Covered by Your Plan:

		Option 1: PPO *Plan pays (on average)*		Option 2: PPO *Plan pays (on average)*	
		In-network	*Out-of-network*	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 14		Under Age 14	
	Oral Exams	100%	100%	100%	100%
	Periodontal Maintenance	100%	100%	100%	100%
	Frequency:	Once Every 3 Months (Enhanced)		Once Every 3 Months (Enhanced)	
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	50%	50%	80%	80%
	Fillings‡	50%	50%	80%	80%
	Perio Surgery	50%	50%	80%	80%
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%	80%	80%
	Root Canal	50%	50%	80%	80%
	Scaling & Root Planing (per quadrant)	50%	50%	80%	80%
	Simple Extractions	50%	50%	80%	80%
	Surgical Extractions	50%	50%	80%	80%
Major Care	Bridges and Dentures	50%	50%	50%	50%
	Inlays, Onlays, Veneers**	50%	50%	50%	50%
	Single Crowns	50%	50%	50%	50%
Orthodontia	Orthodontia	50%	50%	50%	50%
	Limits:	Child(ren)		Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

Manage Your Benefits:

Enrolled members and their dependents can access helpful, secure information about their Guardian benefits at www.guardiananytime.com

Questions?

Call the Guardian Helpline (888) 600-1600
Call weekdays, 7:00 AM to 8:30 PM, EST. And refer to your plan number: 414474

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred 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

Maximum Rollover®

Save Your Dental Annual Maximum Dollars For a Time When You Need Them Most!

With Maximum Rollover, Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). The MRA can be used in further years, if you reach the plan's annual maximum.

To qualify, you must submit a claim for covered services for which a benefit payment is issued, in excess of any deductible or co-pay, and you must not exceed the paid claims threshold during the benefit year.

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

You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

PLAN ANNUAL MAXIMUM **	THRESHOLD	MAXIMUM ROLLOVER AMOUNT	IN-NETWORK ONLY MAXIMUM ROLLOVER AMOUNT	MAXIMUM ROLLOVER ACCOUNT LIMIT
$1000	$500	$250	$350	$1000

** 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.

NOTES:

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2009, the claim activity in 2010 will be used and applied to MRAs for use in 2011.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year.

Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year.

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With Maximum Rollover, Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). The MRA can be used in further years, if you reach the plan's annual maximum.

To qualify, you must submit a claim for covered services for which a benefit payment is issued, in excess of any deductible or co-pay, and you must not exceed the paid claims threshold during the benefit year.

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PLAN ANNUAL MAXIMUM **	THRESHOLD	MAXIMUM ROLLOVER AMOUNT	IN-NETWORK ONLY MAXIMUM ROLLOVER AMOUNT	MAXIMUM ROLLOVER ACCOUNT LIMIT
$1500	$700	$350	$500	$1250

** 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.

NOTES:
Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2009, the claim activity in 2010 will be used and applied to MRAs for use in 2011.

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Finding a Provider

How to Look Up DentalGuard Preferred Providers Online

Guardian's innovative web technology lets you look up a provider right from your computer. Our Find a Provider Search function is simple and easy-to-use. Just follow these steps:

Visit Guardian's web page at www.GuardianAnytime.com:

- Click on "Find A Provider" at the top of the page
- Click on the box that says "Find a Dentist"

On the next web page, follow these easy steps to search:

- Under "Select Your Dental Plan" **Choose PPO**
- Under "Search by" select "Search by Location", "Location & Dentist's Name", or "Location & Office Practice Name".
- Under "Your Location", enter Zip Code or Street Address information
- Under "Distance" select your mile radius, then "Select your Dental Network" **Choose – DentalGuard Preferred** *Note: You also have the option to include type of Dentist, foreign language spoken, and office status in your search.*
- Click "Continue" to view the list of network providers

You can also find a dentist on the go from your smart phone – simply download our app at www.GuardianAnytime.com/mobile.

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GUARDIAN®

Vision Benefit Summary

Group Number: 414474

About Your Benefits:

These days, more and more people are making sure they have access to quality vision care. Regular eye exams not only diagnose vision problems, they provide early detection of serious health problems such as diabetes, hypertension, neurological disorders and brain tumors.

Guardian provides rich, flexible vision plans covering exams and materials – making it more affordable to keep your eyes healthy.

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

	Full Feature - Designer	
Network	Davis Vision	
Your Bi-weekly premium	**$ 2.40**	
You and spouse	$ 4.04	
You and child(ren)	$ 4.11	
You, spouse and child(ren)	$ 6.51	
Copay		
Exams Copay	$ 20	
Materials Copay *(waived for non-formulary elective contact lenses)*	$ 20	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $50
Single Vision Lenses	$0	Amount over $48
Lined Bifocal Lenses	$0	Amount over $67
Lined Trifocal Lenses	$0	Amount over $86
Lenticular Lenses	$0	Amount over $126
Frames	80% of amount over $135*	Amount over $48
Contact Lenses *(Elective and conventional)*	85% of amount over $135*	Amount over $105
Contact Lenses *(Planned replacement and disposable)*	85% of amount over $135*	Amount over $105
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Cosmetic Extras	Avg. 40-60% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	Courtesy discount from most providers	No discounts
Laser Correction Surgery Discount	Up to 25% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every two calendar years	
Network discounts *(cosmetic extras, glasses and contact lenses.)*	Applies to first purchase & courtesy discount from most providers on subsequent purchases.	
Dependent Age Limits (Non-Student/ Student)	20/26	

‡‡Benefit includes coverage for glasses or contact lenses, not both.

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

With the Davis Vision Designer plans, frames from the Fashion or Designer collections are covered in full in excess of the plan's materials copay, if applicable. Frames from the Premier collection are covered in full in excess of a $25 copay applied in addition to the plan's materials copay, if applicable. Frames from a network provider that are not in the collections are covered up to the plan's retail allowance in excess of the plan's materials copay, if applicable.

Contact lenses from Davis Vision's Collection are available at most private practice locations with Full Feature and Materials Only plans. Contacts from the collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.

For Davis Vision, complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period.

Only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use.

**Due to lower prices available at Wal-mart and Sam's Club locations, discounts do not apply. Members will pay 100% of the amount over their allowance.*

Manage Your Benefits:

Enrolled members and their dependents can access helpful, secure information about their Guardian benefits at www.guardiananytime.com

Questions?

Call the Guardian Helpline (888) 600-1600
Call weekdays, 7:00 AM to 8:30 PM, EST. And refer to your plan number : 414474

Find A Vision Provider

Visit www.GuardianAnytime.com
Click on "Find A Provider"

EXCLUSIONS AND LIMITATIONS

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

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-DAVIS-05-VIS et al.

Laser Correction Surgery:

Up to 25% off for vision laser surgery.

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

Contact Lens Collection

DAVISVISION SEE LIFE

- The Davis Vision Contact Lens Collection is available in most participating independent provider offices but not in retail locations. At retail locations your plan-specified Allowance for Contact Lenses will be applied.
- The Collection benefit is offered exclusively with full-feature and materials-only plan designs.*
- Contact lens evaluation and fittings are included at no additional charge when Collection contacts are prescribed.
- Contact lenses not included in the Collection are covered up to the plan's elective contact lens allowance and the copay is waived. In addition, when the evaluation, fit, and lenses are supplied by the same vision provider at the same time, all costs can be applied to the allowance.

TYPE	LENS	MANUFACTURER
Planned Replacement Includes two boxes (Each box of lenses can last up to one year depending on the provider-recommended wearing schedule)	Purevision Proclear Compatibles Frequency 55	Bausch & Lomb ® CooperVision CooperVision
Disposable Includes four boxes	Soflens 38 (6 pack) Focus Dailies (30 pack) Biomedics XC Biomedics 38/Ultraflex 38 Biomedics 55 Clear Site (1-Day 30 pack) Acuvue Acuvue 2 Acuvue Advance Plus 1-Day Acuvue (30 Pack)	Bausch & Lomb ® CIBA Vision ® CooperVision CooperVision CooperVision CooperVision Vistakon Vistakon Vistakon Vistakon

*Available at most participating independent provider offices. All contacts in our Collection are Single-Vision Spherical lenses. Collection is subject to change. A basic copayment may apply.

Members Save on Eyewear Enhancements through Davis Network Discounts

Designer Plan

Spectacle Lenses	Member Cost
All ranges of prescriptions (single vision, bifocal, trifocal)	Included
Choice of glass or plastic lenses	Included
Oversize lenses	Included
Fashion or gradient tinting of plastic lenses	Included
Blended Segment Lenses	$20
Coating - Scratch Resistant	$20
Coating - Ultraviolet	$12
Corning™ Photochromic Glass Lenses	$20
Intermediate Vision Lenses	$30
Polycarbonate Lenses	$30*
Progressive Lenses - Standard	$50
Progressive Lenses (VarilexTM, etc.) - Premium	$90
Coating – Ultra Anti-Reflective	$60
Coating - Premium Anti-Reflective	$48
Coating - Standard Anti-Reflective	$35
Hi-Index Lenses	$55
Plastic Photosensitive Lenses	$65
Polarized Lenses	$75
Eyeglass Breakage Warranty	Included

Prices subject to change

For standard eyeglass lenses, you will receive the lower of the Davis vision discounted charge or Walmart or Sam's Club everyday low price.

*Polycarbonate lenses covered-in-full for monocular patients and patients with prescriptions 6.00 diopters or greater.

www.GuardianLife.com or contact member services at 877-393-7363 for more information

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GUARDIAN®

Life Benefit Summary

Group Number: 414474

About Your Benefits:

Life insurance provides crucial financial protection for your family if something were to ever happen to you. Benefits can be used towards income replacement, a mortgage, tuition, outstanding debt, and more — allowing you to take care of your loved ones even if you are not there. Better yet, this important coverage is being made available to you at economical group rates. Take advantage and enroll today!

What Your Benefits Cover:

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides Basic Life Coverage for all full time employees in the amount of 100% of your annual salary (+$2,000), to a maximum of $200,000 with a minimum amount of $10,000.	$25,000 increments to a maximum of $150,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage equal to one times the employee's life benefits.	Not available
Spouse ‡ Benefit	N/A	50% of employee coverage to a max of $75,000
Child benefit: —children age 14 days to 23 years (25 if full time student) for Voluntary Life	N/A	10% of employee coverage to a max of $10,000. Coverage limits are based on child age.
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.	Underwriting may be required, depending on amount and/or age	We Guarantee Issue coverage for enrollees less than age 65 up to $100,000 per employee, $10,000 for a spouse and $10,000 for dependent children
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take your coverage with you if you terminate employment.	Yes, with age and other restrictions, including evidence of insurability	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived for life, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met

	BASIC LIFE	VOLUNTARY TERM LIFE
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 50% at age 70	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits

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

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style. To help you assess your needs, you can also go to Guardian Anytime and use our Life Insurance Explorer Tool.

Bi-weekly premiums displayed.
Policy Election Cost Per Age Bracket

		< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$25,000 Policy Election Amount											
Employee	$25,000	$.69	$.69	$.69	$1.04	$1.85	$2.89	$4.39	$7.62	$12.58	$20.08
Spouse	$12,500	$.35	$.35	$.35	$.52	$.92	$1.44	$2.19	$3.81	$6.29	$10.04
Child	$2,500	$.20	$.20	$.20	$.20	$.20	$.20	$.20	$.20	$.20	$.20
$50,000 Policy Election Amount											
Employee	$50,000	$1.39	$1.39	$1.39	$2.08	$3.69	$5.77	$8.77	$15.23	$25.15	$40.15
Spouse	$25,000	$.69	$.69	$.69	$1.04	$1.85	$2.89	$4.39	$7.62	$12.58	$20.08
Child	$5,000	$.39	$.39	$.39	$.39	$.39	$.39	$.39	$.39	$.39	$.39
$75,000 Policy Election Amount											
Employee	$75,000	$2.08	$2.08	$2.08	$3.12	$5.54	$8.65	$13.15	$22.85	$37.73	$60.23
Spouse	$37,500	$1.04	$1.04	$1.04	$1.56	$2.77	$4.33	$6.58	$11.42	$18.87	$30.12
Child	$7,500	$.59	$.59	$.59	$.59	$.59	$.59	$.59	$.59	$.59	$.59
$100,000 Policy Election Amount											
Employee	$100,000	$2.77	$2.77	$2.77	$4.15	$7.39	$11.54	$17.54	$30.46	$50.31	$80.31
Spouse	$50,000	$1.39	$1.39	$1.39	$2.08	$3.69	$5.77	$8.77	$15.23	$25.15	$40.15
Child	$10,000	$.79	$.79	$.79	$.79	$.79	$.79	$.79	$.79	$.79	$.79
$125,000 Policy Election Amount											
Employee	$125,000	$3.46	$3.46	$3.46	$5.19	$9.23	$14.42	$21.92	$38.08	$62.89	$100.39
Spouse	$62,500	$1.73	$1.73	$1.73	$2.60	$4.62	$7.21	$10.96	$19.04	$31.44	$50.19
Child	$10,000	$.79	$.79	$.79	$.79	$.79	$.79	$.79	$.79	$.79	$.79
$150,000 Policy Election Amount											
Employee	$150,000	$4.15	$4.15	$4.15	$6.23	$11.08	$17.31	$26.31	$45.69	$75.46	$120.46
Spouse	$75,000	$2.08	$2.08	$2.08	$3.12	$5.54	$8.65	$13.15	$22.85	$37.73	$60.23
Child	$10,000	$.79	$.79	$.79	$.79	$.79	$.79	$.79	$.79	$.79	$.79

Guarantee Issue Amount: Employee $100,000; Spouse $10,000; Child $10,000
Premiums for Voluntary Life Increase in five-year increments
‡**Spouse coverage premium is based on Employee age. Coverage for the spouse terminates at spouse's age 70.**
†Benefit reductions apply.

Manage Your Benefits:

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Questions?

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Call weekdays, 7:00 AM to 8:30 PM, EST.
And refer to your plan number : 414474

LIMITATIONS AND EXCLUSIONS:

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

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

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

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

Voluntary Life Only:

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

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

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details.

For AD&D: We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties er on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within 365 days of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

This handout is for illustration purposes only and is an approximation, premium amounts may be amended.

Tips for buying Life Insurance

Life insurance helps provide financial protection for your family and loved ones. If something were to ever happen to you, life insurance would provide money so that your family and loved ones can continue to manage expenses if you were no longer around. Sample expenses include mortgage payments, legal or medical expenses, childcare, college education and outstanding debts.

If someone depends on you, whether or not you work, chances are you need life insurance. Here are some things to keep in mind when you
buy life insurance:

Know how much Life insurance you need	A very broad rule of thumb is that your life insurance coverage should be 7 to 10 times your income. However, every person's life insurance needs are different. For example, you'll need more insurance if you have four children compared to two or if you have credit card debt versus none. How do you stack up? For a personal estimate on how much life insurance you need, go to the Life and Health Insurance Foundation for Education's website at **www.lifehappens.org**. The online life insurance needs calculator is easy to use and takes just minutes.
A good place to start is at your workplace	If your employer offers a life insurance benefit, think about enrolling in it. A workplace benefit is generally affordable (just a few dollars a month in many cases) and easy to buy. You don't typically need a medical exam to enroll and your employer has done the legwork of finding a quality plan to offer its employees.
Think about supplementing your workplace benefit	Your workplace benefit is a good place to start but may not meet the needs of all people. Know how much your workplace benefit covers. If it's not enough based on your personal estimate, it might make sense for you to supplement it. Consider talking to a financial advisor. Know that, unlike a workplace benefit, when you buy life insurance outside of work a medical exam is usually required.

As things change in your life, your life insurance needs will too. Review your life insurance policy every year. If you've experienced a life milestone like getting married, having a baby or buying a home in the last year, you'll want to make sure your family and loved ones continue to be adequately protected.

ADDITIONAL MATERIALS

The Guardian Life Insurance Company of America
The Guardian Insurance & Annuity Company, Inc.

☐ Midwest Regional Office
PO Box 8012
Appleton WI 54912-8012

☐ Northeast Regional Office
PO Box 26040
Lehigh Valley PA 18002-6040

☐ Western Regional Office
PO Box 2454
Spokane WA 99210-2454

EVIDENCE OF INSURABILITY FOR NON-MEDICAL COVERAGES

Please complete in ink. Erasures and changes invalidate this form.

Planholder Name (Company Name)	Group Plan No.

Complete the following information for each person to be underwritten:

Name (Last, First, Middle Initial)	Sex	Birthdate	Height	Weight	Full Time Student?
Employee:	☐ M ☐ F				
Spouse:	☐ M ☐ F				
Child:	☐ M ☐ F				☐ Yes ☐ No
Child:	☐ M ☐ F				☐ Yes ☐ No

Employee's Social Security Number	Home Phone Number	Cell Phone Number	Date of Marriage	Employee's Place of Birth (State)

Email Address	How Best to Contact

IF APPLYING FOR LIFE INSURANCE: questions 1-4 must be answered for each person to be underwritten
IF APPLYING FOR DISABILITY INSURANCE: all five questions must be answered in reference to the employee only

1. In the past 10 years been treated for or diagnosed as having: heart; liver or kidney disorder; neurological disorder; diabetes; stroke; cancer; tumor; mental or nervous disorder; AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex (ARC); or been advised to have treatment for drug abuse (including prescription drugs); or alcoholism?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
2. In the past 5 years used illegal drugs?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
3. In the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); lymphadenopathy (enlarged or swollen glands)?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
4. Excluding HIV testing and AIDS/ARC, in the past year: (a) consulted or been examined by or treated by a physician, practitioner or specialist? (Include routine physicals only when there is an existing or newly diagnosed medical condition); (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation?; (c) been prescribed medication(s) - (other than for colds, flu or allergies)?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
5. **If applying for disability coverage, please complete these additional questions:** (a) In the past 5 years, been treated for conditions of the back, neck, spine, or arthritis?; (b) Are you currently pregnant?; (c) Excluding your employer sponsored group disability plan, are you currently insured for any other disability coverage? If **"Yes"**, what is the total amount of coverage already in-force? $_____	**Employee** ☐ Yes ☐ No

Be certain to read, sign and date this application on the reverse side.
For each "Yes" answer to questions 1 through 5b give details below. (*Continue on reverse side if additional space is needed.)

Ques. No.	Name of Patient	Practitioner's Name & Address	Hospital Name & Address	Condition	Duration of symptoms, treatment & degree of recovery	Dates mo/yr

ENDORSEMENT (GUARDIAN USE ONLY)

Employee: ☐ Approved ☐ Declined Optional Life: $	Premium Class: ☐ Preferred ☐ Standard Guardian's Universal Life: $	**Child:** ☐ Approved ☐ Declined Optional Life: $ Child Term Rider: $
Spouse: ☐ Approved ☐ Declined Optional Life: $	Premium Class: ☐ Preferred ☐ Standard Spouse Term Rider: $	Excess Life $_____ ☐ Approved ☐ Declined Long Term Disability $_____ ☐ Approved ☐ Declined Short Term Disability $_____ ☐ Approved ☐ Declined

Effective Date:	By:	Date:	Vice President
			Stuart J. Shaw

*** Additional space if questions 1 through 5b were answered "Yes".**

Ques. No.	Name of Patient	Practitioner's Name & Address	Hospital Name & Address	Condition	Duration of symptoms, treatment & degree of recovery	Dates mo/yr

I hereby represent that the statements and answers to the questions on this application are to the best of my knowledge and belief, full, complete and true. I understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (in the case of a late entrant, it is not at the Company's expense), that I be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted and approved by the Insurance Company at the Home Office as shown in the Endorsement; and (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I will become insured on the date I do return to work and satisfy a waiting period (as defined in the Group Plan) of full-time service; (3) coverage for my dependents will not take effect if a dependent other than a newborn is: (a) confined to the hospital or other health care facility; or (b) is unable to perform the normal activities of someone of like age and sex; (4) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (5) the employer is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

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

Investigative Consumer Report
I authorize The Guardian Life Insurance Company of America or The Guardian Insurance and Annuity Company to obtain or have prepared an investigative report as described in the Insurance Information Practices Notice.

Medical Records and Other Information

I authorize any physician, medical practitioner, hospital, clinic, other health facility, the MIB, Inc., insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my eligible dependents to The Guardian Life Insurance Company of America or The Guardian Insurance and Annuity Company or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my eligible dependents.

I understand The Guardian Life Insurance Company of America or The Guardian Insurance and Annuity Company will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

I know that I may request and receive a copy of this authorization.

I agree that a photocopy of this authorization will be as valid as the original.

I acknowledge receipt of and have read Guardian's Insurance Information Practices Notice regarding its Insurance Information Practices, the Fair Credit Reporting act, the Medical Information Bureau and Medical Records.

I agree that this authorization will be valid for two and one half years from the date shown below.

Signature of Employee x	**Date**
Signature of Spouse x	**Date**
Signature of Child x (if over 18)	**Date**

INSURANCE INFORMATION PRACTICES NOTICE
Read and Detach for your records

Thank you for choosing Guardian insurance. This Insurance Information Practices Notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information.

Fair Credit Reporting Act Pre-Notice: When we begin to process your application, we may ask for a consumer report from a consumer reporting agency. All or part of that report may be an investigative consumer report. Such a report will include information about your character, general reputation, personal characteristics or mode of living except as may be related directly or indirectly to your sexual orientation. It will be obtained through personal interviews with people who know you. You may request to be interviewed in connection with this report. We may request later consumer reports, other than an investigative consumer report, at a future update, renewal or extension of the insurance for which you have applied.

At your request, we will tell you if we have asked for a consumer report or an investigative consumer report in the initial processing of your application. If we have, we will tell you the name and address of the consumer reporting agency to which we have made our request for a report. You may inspect and receive a copy of such report by contacting the consumer reporting agency directly. At your written request, we will give you more detailed information about the nature and scope of this kind of investigation.

"I authorize The Guardian Life Insurance Company of America or its reinsurers to make a brief report of my protected health information to MIB, Inc.

MIB, Inc., Pre-Notice: "Information regarding your insurability will be treated as confidential. Guardian, or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc., Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file."

"Upon receipt of a request from you MIB, Inc., will arrange disclosure of any information it may have in your file. Please contact MIB, Inc., at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB, Inc., file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc., information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734."

"Guardian, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted." Information for consumers about MIB, Inc., may be obtained on its website www.mib.com

Medical Records: We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

I hereby represent that the statements and answers to the questions on the attached form are, to the best of my knowledge and belief, full, complete and true. I understand that they shall form the basis upon which I may be included for insurance.

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

I authorize any physician, medical practitioner, hospital, clinic, other health facility, the MIB, Inc., insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my eligible dependents to The Guardian Life Insurance Company of America or The Guardian Insurance and Annuity Company or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my eligible dependents.

I understand The Guardian Life Insurance Company of America or The Guardian Insurance and Annuity Company will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

I know that I may request and receive a copy of this authorization.

I agree that a photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of and have read Guardian's notice regarding its Insurance Information Practices Notice.

I agree that this authorization shall be valid for two and one half years from the date signed.

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THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

GUARDIAN®

Group Insurance Enrollment/Change Form

Northeast Regional Office, P.O. Box 26040,
Lehigh Valley, PA 18002-6040

Please print clearly and mark carefully.

Employer Name: **Ellenville Regional Hospital**	Group Plan Number: **414474**	Benefits Effective:_____
PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change		

Class: Class 2-Working 36+ hours Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:

First, MI, Last Name:

Social Security Number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address	City	State	Zip

Gender: ❑ M ❑ F Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) -

Email Address:

Are you married or do you have a spouse? ❑ Yes ❑ No Date of marriage/union:____-____-_____

Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-_____

About Your Job: Hours worked per week: _____ Job Title:

Work Status: ❑ Active ❑ Retired ❑ Cobra/State Continuation	Date of full time hire: ____ - ____ - ____	Annual Salary: $_____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

		Gender	Date of Birth (mm-dd-yyyy)	
Spouse (First, MI, Last Name)		❑ M ❑ F	____ - ____ - ____	
Child/Dependent 1:	❑ Add ❑ Drop	❑ M ❑ F	____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 2:	❑ Add ❑ Drop	❑ M ❑ F	____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 3:	❑ Add ❑ Drop	❑ M ❑ F	____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 4:	❑ Add ❑ Drop	❑ M ❑ F	____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Dec 04, 2013

Drop Coverage:

❑ Drop Employee ❑ Drop Dependents

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

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Dental ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Vision ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Basic Life

❑ Voluntary Life ❑ Employee ❑ Spouse ❑ Child(ren)

Loss Of Other Coverage:

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

❑ Termination of Employment: _____-_____-_____

❑ Divorce _____-_____-_____

❑ Death of Spouse _____-_____-_____

❑ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ❑ Dental ❑ Vision

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

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

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

Your Bi-weekly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse& Dependent/Child(ren)
Option 1: PPO	❑ $17.74	❑ $33.03	❑ $40.49	❑ $55.79
Option 2: PPO	❑ $21.71	❑ $40.43	❑ $48.62	❑ $67.34

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

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

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

Your Bi-weekly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature - Designer	❑ $2.40	❑ $4.04	❑ $4.11	❑ $6.51

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

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

Basic Life Coverage with Accidental Death and Dismemberment (AD&D):

Benefit reductions apply. Please see plan administrator.

Policy Amount

Employee Only

☑ 100% of your annual salary to maximum $200,000

NAME YOUR BENEFICIARIES (primary beneficiaries must total 100%)

Primary Beneficiary:

Name_____ %_____

Relationship to employee:_____

Name_____ %_____

Relationship to employee:_____

Contingent Beneficiary:_____

Relationship to employee:_____

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

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

Important Notes:

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

Guardian Group Plan Number: **414474** Please print employee name:

Voluntary Term Life Coverage:

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

Employee

Policy Amount ***Check one box only***

❑ $25,000 ❑ $50,000 ❑ $75,000 ❑ **$100,000*** ❑ $125,000 ❑ $150,000

**Guarantee Issue Amount*

❑ I do not want this coverage

***Add* Voluntary Life for Spouse**

❑ 50% of employee's amount to maximum $75,000

The Guarantee Issue Amount is $10,000.

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

❑ I do not want this coverage

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

❑ 10% of employee's amount to maximum $10,000

The Guarantee Issue Amount is $10,000.

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

❑ I do not want this coverage

Important Notes:

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

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

Primary Beneficiaries:

Name:_____%_____

Relationship to employee: _____

Name:_____%_____

Relationship to employee: _____

Contingency Beneficiary:_____

Relationship to employee:_____

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

Signature

- An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- You must be legally working in the United States, its possessions or the countries of Canada and Mexico 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. You must be legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.
- 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 has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of Guardian insurance related documents, in lieu of paper copies, to the extent permitted by applicable law ❑ I voluntarily agree to that arrangement. ❑ I do not agree to that arrangement. I understand that I may change my election by providing Guardian thirty (30) day prior written notice.
- **I state 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 statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil Penalties, or denial of insurance benefits (Does not apply to Life Insurance).

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

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

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

Enrollment Kit 414474, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form, as a substitute for fraud warnings that appear in other areas of the claim form:

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

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

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.

Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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 knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or 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 confinement in state prison.

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

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

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

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

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

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

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

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER