2017 Benefits Open Enrollment

October 1 through November 13, 2016

The 2017 Benefits Open Enrollment Period has now begun! Your Open Enrollment Packet includes everything you need to enroll in, make changes to and review the benefit options available to you in 2017.

All benefits elected during the Open Enrollment Period will go into effect on January 1, 2017 and run through December 31, 2017. Payroll deductions for these benefits will begin on December 1, 2016. Employees are not able to make changes to elected benefits during the Plan Year unless they or a family member experience a Qualifying Life Event (QLE). QLE's include marriage, divorce, death, birth, or loss of other coverage.

Failure to respond or participate in the 2017 Benefits Open Enrollment Period will result in an automatic continuation of current benefits. Employees that are not currently enrolled in benefits and do not make an election during the Open Enrollment Period will not be able to enroll in benefits until the following Plan Year.

Open Enrollment Instructions

****If you are not making any changes to your benefits, you do not need to complete any paperwork****

1. Complete and sign the Employee Election Form
2. Complete and sign each application for the benefit(s) in which you would like to enroll
3. Return completed forms to SimpleHR

Scan
acurtin@simplehr.com

Fax
850.650.9936

Mail
SimpleHR Benefits Department
36474 Emerald Coast Parkway, Building B
Destin, FL 32541

For questions or more information, please contact Ashley Curtin, Benefits Manager, at 850-650-9935 ext. 37 or visit our website at www.simplehrbenefits.com

Deadline is November 13, 2016

2017 Dental Benefit Plans

Guardian DentalGuard Preferred | www.guardiananytime.com | (800)541-7846

Monthly Rates	Guardian Dental Plan #1	Guardian Dental Plan #2
Employee Only	Contact SimpleHR for Rates	
Employee and Spouse		
Employee and Child(ren)		
Employee and Family		

Type 1 – Preventative/Diagnostic — *Fluoride Treatments (under age 19), X-Rays, Cleanings, Periodic Exams*

Type 2 – Restorative — *Simple Extractions, Fillings, Stainless Steel Crown*

Type 3 – Major Restorative — *Removal of Impacted Teeth, Oral Surgery, Root Canals, Bridges, Crowns, Dentures*

Guardian DentalGuard Preferred Plan #1

Benefit Structure	IN NETWORK	OUT OF NETWORK
Calendar Year Deductible	$50 per Individual $150 Family Maximum	$100 per Individual $300 Family Maximum
Type I - Preventive/Diagnostic	0%	0%
Type II – Restorative	20% after Deductible	20% after Deductible
Type III - Major Restorative	50% after Deductible	50% after Deductible
Maximum Benefit per Year Type I, II, and III	$2,000 per person	$1,000 per person
Type IV – Orthodontia (ages 6-18) Lifetime Maximum	$1,500	$1,500

Guardian DentalGuard Preferred Plan #2

Benefit Structure	IN NETWORK	OUT OF NETWORK
Calendar Year Deductible	$50 per Individual $150 Family Maximum	$100 per Individual $300 Family Maximum
Type I - Preventive/Diagnostic	20%	20%
Type II - Restorative	30% after Deductible	30% after Deductible
Maximum Benefit Year Type I and II	$1,000	$1,000

This handout is for illustrative purposes. You will receive benefit booklets. If there is a discrepancy between this handout and your benefit booklet, the benefit booklet prevails.

2017 Vision Benefit Plan

Guardian Vision Service Plan (VSP) | www.guardiananytime.com | (800)541-7846

Monthly Rates	Guardian VSP Vision
Employee Only	Contact SimpleHR for Rates
Employee and Spouse	
Employee and Child	
Employee and Family	

Plan Features

Type of Service	IN NETWORK	OUT OF NETWORK
Exam Frequency	Every 12 Months	
Exam Copay	$10.00 Copay	$46.00 Maximum after Copay
Lens Frequency	Every 12 Months	
Single Vision	$25.00 Copay	$47.00 Maximum after Copay
Bifocal	$25.00 Copay	$66.00 Maximum after Copay
Trifocal	$25.00 Copay	$85.00 Maximum after Copay
Lenticular	$25.00 Copay	$125.00 Maximum after Copay
Contact Lens Frequency*	Every 12 Months	
Medically Necessary	$25.00 Copay	$210.00 Maximum after Copay
Elective	$120.00 Maximum (Copay Does Not Apply)	
Frames Frequency	Every 24 Months	
Frames Allowance	Covered up to $120.00**	$47.00 Maximum after Copay

*If contact lenses are chosen, then you will not be eligible to receive lenses for 12 months and a frame for 24 months following the date that the contacts were obtained.

**If you select a frame that exceeds the retail allowance, the plan will cover 20% of the amount above the allowance. The remaining balance is the responsibility of the plan holder.

Note: Lens coverage includes polycarbonate lenses for children up to the plan's non-student dependent age limit of 19 (26 full-student)

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-VSN-96-VIS et al.

2017 Supplemental Life and Accidental Death and Dismemberment (AD&D)

Guardian Voluntary Life Insurance | www.guardiananytime.com | (800)541-7846

Life insurance pays a benefit to your beneficiary (whomever you designate to receive the benefit) upon your death resulting from an accident or illness. If the death is the result of an accident, the payment may be increased based on a schedule found within the policy.

An employee may choose to purchase Supplemental Term Life Insurance and AD&D in increments of $10,000, up to a maximum of $500,000. During an employee's initial eligibility (first 60 days of employment), Supplemental Term Life Insurance is guaranteed issue up to $100,000. Any amount requested above $100,000 or requested outside of an employee's initial eligibility window is subject to Evidence of Insurability.

Spousal Life Insurance

An employee may choose to cover their spouse at 50% of the employee's coverage amount, up to a maximum of $250,000. The monthly rate is based on the employee's age.

Dependent Life Insurance

An employee may choose to cover their dependent child(ren) at 10% of the employee's coverage amount, up to a maximum of $10,000. The monthly rate covers all dependent children.
The rate is $0.16 per $1,000 of coverage.

MONTHLY RATES (per $10,000 of coverage)	Employee	Spouse (50% of Employee election)	Child(ren) (10% of Employee election)
Under 30 years old	Contact SimpleHR for Rates		
30-34			
35-39			
40-44			
45-49			
50-54			
55-59			
60-64			
65-69			
70 years old and older			

Age Reduction Information

The above life benefits reduce from the original amount by 35% at age 65, 60% at age 70, 75% at age 75, and 85% at age 80. The age reduction schedule is based on the covered person's own age.

2017 Allstate Products Overview

Allstate Benefits | www.allstatebenefits.com | (800)521-3535

Group Products

Personal Accident Indemnity

Guarantees coverage for accidents on and off the job

$200 Outpatient ER Treatment	$200 Ambulance/ $600 Air Ambulance
$2,000 Hospital Confinement	$400 Daily Hospital Benefit ($800 for ICU)
$50 Physician Visit Benefit	Fractures, surgery benefits, and much more!

Supplemental Health

Provides cash benefit for hospitalization, surgery, outpatient care, nursing, and non-local transportation

$330 Daily Hospitalization	$330 ICU (daily)
$41 Physician Visit	$415 Outpatient ER Treatment

Critical Illness

Offers financial support if diagnosed with a covered critical illness

$10,000 or $20,000 cash benefit provided if diagnosed with a qualifying critical illness. Spouse and/or Child(ren) are covered at 50% basic benefit amounts. Recurrence Benefit pays 25% of the benefit if diagnosed more than once in a category of illnesses.

Covered critical illnesses include: Heart Attack, Stroke, Invasive Cancer, Paralysis, Major Organ Transplant, and Alzheimer's

Individual Products

Short-Term Disability

While most Americans insure their lives and material assets, like their homes and cars, many overlook the necessity to protect their most valuable asset – their ability to earn an income.

Features

- Provides short-term accident or sickness disability benefits for Total or Partial Disability
- Employees choose monthly benefits from $400 to $5,000 per month, up to 60% of the applicant's current gross income
- Age banded Rates: Ages 18 – 49, 50 – 59, 60 – 69
- Portable Coverage: Employees may keep coverage after leaving employment, by paying premium directly to Allstate Benefits

Universal Life

This benefit enables employees to prepare for their family's future without straining their household budget. While funds accumulate, the policy owner is protected by immediate life insurance coverage. Universal Life combines the low-cost protection of term insurance with a fund value feature which earns tax-deferred interest at competitive interest rates. Premiums can be raised or lowered as an employee's budget changes and Death Benefits can be raised or lowered as an employee's needs change.

Features

- Underwriting: Varies for Employee, Spouse, and Children; please see representative for more information
- Flexible Premiums = Flexible Insurance
- Income tax-free death benefit paid to a beneficiary the insured designates
- The coverage is portable as long as premiums are paid to Allstate Benefits

*For complete schedule of benefits please refer to the Summary Plan Description for each policy

SimpleHR 2017 Benefits – Employee Election Form

Client Name	Employee Name		
Date of Birth	SSN#		
Address	City	State	Zip Code

Only Full Time employees (25+ hours per week) are eligible for benefits.

Please note that additional applications will be required for all elected benefits.

Please return all completed forms and applications to SimpleHR:

Phone: 850.650.9935 ext. 37

Fax: 850.650.9936

Email: acurtin@simplehr.com

ENROLLMENT OPTIONS OR CHANGES

GUARDIAN DENTAL, VISION (VSP), AND LIFE INSURANCE

	Dental	Vision	Life
Add Coverage	☐	☐	☐
Change Coverage	☐	☐	☐
Waive Coverage	☐	☐	☐

ALLSTATE SUPPLEMENTAL HEALTH PRODUCTS

	Accident	Critical Illness	Group Supplemental	Individual Products
Add Coverage	☐	☐	☐	☐
Change Coverage	☐	☐	☐	☐
Waive Coverage	☐	☐	☐	☐

ELECTION / DECLINATION ACKNOWLEDGEMENT

I understand that this election form revokes any prior election forms completed and will remain in effect and cannot be revoked or changed during the Plan Year, unless there is a change in family status, employment, or other reasons as outlined by the IRS rules for the Section 125 Plan. I understand I must complete an Enrollment Application for each benefit in which I elect coverage. I understand and agree that I am fully responsible at all times for any benefit premiums for which I have authorized and such premiums will be deducted from my wages when due.

Signature _____ Date _____

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

Please print clearly and mark carefully.

Employer Name: **SIMPLE HR**	Group Plan Number: **00420706**	Benefits Effective:_____

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

Class: ALL ELIG EES NOT ENROLLED IN THE ER BASIC LIFE 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: 25-40+ Job Title: N/A

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

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

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

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

Drop Coverage:

❑ Drop Employee ❑ Drop Dependents

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

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

❑ Dental ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Vision ❑ Employee ❑ Spouse ❑ Child(ren)

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

Loss Of Other Coverage:

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

❑ Termination of Employment: _____-_____-_____

❑ Divorce _____-_____-_____

❑ Death of Spouse _____-_____-_____

❑ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ❑ Dental ❑ Vision

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

❑ Covered under another insurance plan

❑ Other _____

(additional information may be required)

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

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: BuyUp Plan	❑	❑	❑	❑
Option 2: Core Plan	❑	❑	❑	❑

❑ 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.**

	Employee Only	Employee and 1 Dependent	EE, Spouse & Dependent/Child(ren)
Full Feature	❑	❑	❑

❑ 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

LIFE INSURANCE *continued*

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

Employee

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

❑ $10,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000	❑ $60,000
❑ $70,000	❑ $80,000	❑ $90,000	❑ $100,000	❑ $110,000	❑ $120,000
❑ $130,000	❑ $140,000	❑ $150,000	❑ $160,000	❑ $170,000	❑ $180,000
❑ $190,000	❑ $200,000	❑ $210,000	❑ $220,000	❑ $230,000	❑ $240,000
❑ $250,000	❑ $260,000	❑ $270,000	❑ $280,000	❑ $290,000	❑ $300,000
❑ $310,000	❑ $320,000	❑ $330,000	❑ $340,000	❑ $350,000	❑ $360,000
❑ $370,000	❑ $380,000	❑ $390,000	❑ $400,000	❑ $410,000	❑ $420,000
❑ $430,000	❑ $440,000	❑ $450,000	❑ $460,000	❑ $470,000	❑ $480,000
❑ $490,000	❑ $500,000				

*Conditional Issue Amount

❑ I do not want this coverage

***Add* Voluntary Life for Spouse**

❑ 50% of employee's amount to maximum $250,000

The Conditional Issue Amount is $50,000.

****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 Conditional 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 beneficiary percentages must total 100%)

Primary Beneficiaries:

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

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

Phone: **Relationship to Employee:**_____

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

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

Phone: **Relationship to Employee:**_____

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

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

Phone: **Relationship to Employee:**_____

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

Health History

Complete the following question(s) if you are enrolling for one or more of the following benefits listed below. NOTE: Additional information may be required.

Voluntary Life

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

In the last 6 months have you or any of your dependents received diagnosis and/or treatment by a licensed medical professional for medical care, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; or any other Chronic Condition? (Being breast cancer free for 2 or more years and any follow-up does not disqualify an applicant)

❑ 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.

Have you or any of your dependents tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or AIDS caused by the HIV infection or other sickness or condition derived from such infection?

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

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

Signature

- An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- 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.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- **I attest that the information provided above is true and correct to the best of my knowledge.**

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

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

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

Fraud Warning Statements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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; 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. Ever tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	Employee ☐Yes ☐No Spouse ☐Yes ☐No Child ☐Yes ☐No
4. 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

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

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 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 agree that this authorization will be valid for two and one half years from the date shown below and I have read, understand, and accept the statements and provisions on the reverse side of this application.

Signature of Employee x _____ Date _____

Signature of Spouse x _____ Date _____

ENDORSEMENT (GUARDIAN USE ONLY)

Employee: ☐ Approved ☐ Declined	Premium Class: ☐ Preferred ☐ Standard	Child: ☐ Approved ☐ Declined	
Optional Life: $	Guardian's Universal Life: $	Optional Life: $	Child Term Rider: $
Spouse: ☐ Approved ☐ Declined	Premium Class: ☐ Preferred ☐ Standard	Excess Life $	☐ Approved ☐ Declined
		Long Term Disability $	☐ Approved ☐ Declined
Optional Life: $	Spouse Term Rider: $	Short Term Disability $	☐ Approved ☐ Declined
Effective Date:	By:	Date:	Vice President Stuart J. Shaw

I hereby represent that the statements and answers to the questions on the reverse side 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 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.

I understand The Guardian Life Insurance Company of America 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 Guardian's notice regarding its insurance information practices, and medical records.

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* 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

Read and Detach for your records

Thank you for choosing Guardian insurance. This 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. If you wish a more detailed explanation of our information practices, please send your written request to Corporate Secretary, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-4025.

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.

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 Insurance Company's expense), that I be examined by an accredited medical examiner selected by the Company, (2) no Group Insurance shall 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 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.

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 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 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 Guardian's notice regarding its insurance information practices, and medical records.

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

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT FORM

☐ New Certificate ☐ Change/Increase Certificate # _____

Remarks:	This box for AHL Home Office use only

GENERAL INFORMATION

Employee's Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number	
Residence Address	City	State	Zip
Date of Birth / Phone Number	Email		
Employer/Association/Union **Simple HR** / Date Hired	Occupation	Plant Or Division	
Primary Beneficiary's Full Name and Address / City / State / Zip	Relationship		
Phone Number / Date of Birth	Social Security Number		
Contingent Beneficiary's Full Name and Address / City / State / Zip	Relationship		
Phone Number / Date of Birth	Social Security Number		

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Last Name	First Name	Relationship	Sex	Date of Birth	Social Security Number	Tobacco Use* (Critical Illness)
		Employee				** ☐ Yes ☐ No
		Spouse				** ☐ Yes ☐ No

***Has any adult (19 and older) person to be insured used tobacco in the last 12 months? (**If applying for Critical Illness.)**

Are you applying for coverage or changing existing coverage due to a qualifying event?

Accident ☐ Yes ☐ No **Critical Illness** ☐ Yes ☐ No **Hospital Indemnity** ☐ Yes ☐ No

If "Yes", check the qualifying event:

☐ Marriage ☐ Spouse/Dependent Child Death ☐ Newly Eligible
☐ Divorce ☐ Eligible/Ineligible Child ☐ Termination
☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Employee Death

Date of Qualifying Event _____ Current Certificate Number(s) _____

Do you currently have any of the following Individual coverages with American Heritage Life Insurance Company (AHL)?

Accident ☐ Yes ☐ No Critical Illness ☐ Yes ☐ No Hospital Indemnity ☐ Yes ☐ No

If you answered "Yes" to any of the coverages, please enter the Policy Number _____

Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter effective date of termination _____

Premium/Billing Mode ☒ Monthly Date of First Deduction _____ Coverage Effective Date _____	Account Number	Employee ID	Situs State
	GA746		**FL**

ENROLLMENT FORM
SELECTION OF COVERAGE

(Answer Yes or No and complete for each coverage selected)

* 0 1 0 8 3 1 0 1 *

Accident (GVAP6) On and Off the Job Accident ☐ Yes ☐ No	Base Units 4	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Monthly Premium $_____	**Home Office Use Only**

☒ Accident Treatment & Urgent Care Rider **Units** 2	☒ Dislocation/Fracture Rider **Units** 2
☒ Emergency Room Services Rider **Units** 2	☒ Benefit Enhancement Rider **Units** 2
☒ Outpatient Physician's Rider **Units** 2	☒ Accidental Death, Dismemberment and Functional Loss Rider **Units** 1

Critical Illness (GVCIP1) (My Lifeline) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Monthly Premium $_____	**Home Office Use Only**

Basic Benefit Amount ☐ **$10,000 - or -** ☐ **$20,000**

If covered, Basic Benefit Amount for spouse or other dependents is 50% of the employee's.

☒ Critical Illness Cancer Option	☒ Recurrence Option	☒ Wellness Option Units 2

Hospital Indemnity (GVSP1) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Monthly Premium $_____	**Home Office Use Only**

Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related
Units	2	1	1

ACCEPTANCE/AUTHORIZATION: I hereby request all coverage(s) checked "yes" above for which I am or may become eligible under the group coverages issued by AHL. **I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **EFFECTIVE DATE:** I understand that the "effective date" of my elected coverages will be the effective date recorded on my Certificate, not the date this Enrollment form is signed. **WAIVER/DECLINATION**: I understand that if I refuse any coverage for which I am eligible (by checking "no" above), satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

FRAUD NOTICE: 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.

Date Signed _____ Employee's Signature _____

Agent's (Producer's) Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Signature of Soliciting Florida Agent (Producer) _____

Print Soliciting Agent (Producer) Name _____

Florida Agent License Number _____

To be completed by home office or agent (producer), prior to issue:

Agent (Producer) Name	**Agent (Producer) Number**	**National Agent (Producer) Number (NPN)**	**Percentage Credit**
Servicing Agent (Producer):			%
Soliciting Agent (Producer):			%
			%
			%
			%

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

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