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

Please print clearly and mark carefully.

Employer Name: COUNTY OF SUMMIT | Group Plan Number: 00576937 | Benefits Effective:_____

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

Class: VOLUNTARY LIFE-VOLUNTARY AD&D | Division:_____ | Subtotal Code:_____ (Please obtain this from your Employer)

About You:

First, MI, Last Name:

Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address | City | State | Zip

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

Email Address:

Are you married or do you have a spouse? ❑ Yes ❑ No
Do you have children or other dependents? ❑ Yes ❑ No

Date of marriage/union:____-____-_____
Placement date of adopted child: ____-____-_____

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*

❑ $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*

*Guarantee Issue Amount.

❑ I do not want this coverage

Add Voluntary Life for Spouse

Policy Amount

❑ $5,000	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000
❑ $35,000	❑ $40,000	❑ $45,000	❑ $50,000*	❑ $55,000	❑ $60,000
❑ $65,000	❑ $70,000	❑ $75,000	❑ $80,000	❑ $85,000	❑ $90,000
❑ $95,000	❑ $100,000	❑ $105,000	❑ $110,000	❑ $115,000	❑ $120,000
❑ $125,000	❑ $130,000	❑ $135,000	❑ $140,000	❑ $145,000	❑ $150,000

**Guarantee Issue Amount*

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

❑ I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

❑ $5,000*

**Guarantee Issue Amount*

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

❑ I do not want this coverage

Have you used any form of tobacco in the past 6 months (e.g., pipe, chewing tobacco) and/or have you smoked cigarettes in the past 12 months?

Employee Yes ❑ No ❑ | Spouse Yes ❑ No ❑

Important Notes:

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

LIFE INSURANCE *continued*

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

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

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

Phone: ( ) - Relationship to Employee:_____

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

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

Phone: ( ) - Relationship to Employee:_____

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

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

Phone: ( ) - Relationship to Employee:_____

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

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

Accidental Death and Dismemberment Coverage:

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

Employee Only

Policy Amount

❑ $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*

❑ I do not want this coverage

Add Entire Family (includes Employee, Spouse and Child(ren))

❑ Spouse 50% of employee's amount & Child(ren) 10% of employee's amount

❑ I do not want this coverage

Signature

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- 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.
- 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.
- I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.
- I understand that my coverage will not be effective until approved by 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, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

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

SIGNATURE OF EMPLOYEE X _____ DATE _____