GUARDIAN®

The Guardian Life Insurance Company of America
And its Affiliates and Subsidiaries

Basic Life, LTD, STD, Voluntary Life, Dental, and Vision Enrollment/Change Form

P.O. Box 14319
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: Tusculum Group Plan Number: 00498351 Benefits Effective: 04/01/2018

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

Class: 001 __ Choose one: **001** - All Employees except President/Vice President **002** -Vice Presidents **003** - President

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: 40 Job Title: _____

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

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.***

Spouse (First, MI, Last Name)	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) _____/_____/_____ Social Security Number _____ - _____ - _____	
Child/Dependent 1:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) _____/_____/_____ Social Security Number _____ - _____ - _____	Status (check all that apply) ❑ Student (if over age 24) ❑ Disabled ❑ Non standard dependent
Child/Dependent 2:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) _____/_____/_____ Social Security Number _____ - _____ - _____	Status (check all that apply) ❑ Student (if over age 24) ❑ Disabled ❑ Non standard dependent
Child/Dependent 3:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) _____/_____/_____ Social Security Number _____ - _____ - _____	Status (check all that apply) ❑ Student (if over age 24) ❑ Disabled ❑ Non standard dependent
Child/Dependent 4:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) _____/_____/_____ Social Security Number _____ - _____ - _____	Status (check all that apply) ❑ Student (if over age 24) ❑ Disabled ❑ Non standard dependent

Guardian Group Plan Number: 00498351 Please Print Employee Name _____

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.

PPO	❑ Employee Only	❑ EE & Spouse	❑ EE & Dependent/Child(ren)	❑ EE, Spouse & Dependent/Child(ren)
	$29.48	$64.85	$53.35	$96.68

❑ I do not want this coverage. If you do not want 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.

❑ I do not wish to change my current coverage(s)

Vision 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)
$8.10	$13.34	$13.60	$22.01

❑ I do not want this coverage. If you do not want 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.

❑ I do not wish to change my current coverage(s)

Questions? Call the Guardian Help line (888) 600-1600 *www.guardianlife.com*

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Guardian Group Plan Number: 00498351 Please Print Employee Name _____

Basic Life Coverage With Accidental Death and Dismemberment (AD&D): Check only one box. Benefit reductions apply. Please see plan administrator.

Policy Amount
Employee Only

☑ $20,000.00
The Guarantee Issue Amount is $20,000.

❑ I do not wish to change my current beneficiary(ies)

NAME YOUR BENEFICIARIES (primary beneficiary percentages must total 100%)

Primary Beneficiaries:

Name_____ _____**%**

Relationship to employee: _____ SSN: _____

Name_____ _____**%**

Relationship to employee: _____ SSN _____

Contingent Beneficiary: _____ _____**%**

Relationship to employee: _____ SSN _____

Total _____**%**

(In the event the designated 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 coverage 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 Voluntary Life.

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.

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

**Guaranteed Issue Amount* ***Guaranteed Issue Amount plus Additional Amount*

❑ I do not want this coverage ❑ I do not wish to change my current coverage(s)

***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* ***Guarantee Issue Amount plus Additional Amount*

****The amount may not be more than 50% of the employee amount tor Voluntary life.***

❑ I do not want this coverage ❑ I do not wish to change my current coverage(s)

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

Policy Amount

❑ **$10,000***

**Guarantee Issue Amount*

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

❑ I do not want this coverage ❑ I do not wish to change my current coverage(s)

Questions? Call the Guardian Help line (888) 600-1600 *www.guardianlife.com*

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Guardian Group Plan Number: 00498351 Please Print Employee Name _____

LIFE INSURANCE ***continued***

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%) If electing different beneficiaries that are not the same as those named for Basic Life, please name below.

❑ **I do not wish to change my current beneficiary(ies)**

Primary Beneficiaries: (Voluntary Insurance)

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

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

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

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

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

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

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

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

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

Total _____%

Contingent Beneficiary:

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

Date of Birth (mm-dd-yyyy): _____/_____/_____ 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.

Short-Term Disability (STD) Coverage: The weekly amount may not exceed 60% of your weekly salary

Weekly Benefit

❑ $50.00	❑ $200.00	❑ $350.00	❑ $500.00	❑ $650.00	❑ $800.00	❑ $950.00
❑ $100.00	❑ $250.00	❑ $400.00	❑ $550.00	❑ $700.00	❑ $850.00	❑ $1,000.00
❑ $150.00	❑ $300.00	❑ $450.00	❑ $600.00	❑ $750.00	❑ $900.00	

❑ I do not want this coverage ❑ I do not wish to change my current coverage(s)

Long-Term Disability (LTD) Coverage:

Monthly Benefit

☑ 60% of salary to a maximum of $5,000

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

In the last 6 months have you or any of your dependents received medical care, including treatment, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; any condition related to Acquired Immune Deficiency Disorder (AIDS) or AIDS Related Complex; or any other Chronic Condition?

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

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

Signature

- An employee's decision to elect Dental and/or Vision or not elect Dental and/or Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in Dental and/or 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 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.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at
- your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that 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.
- 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 the 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-day (30) 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 any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

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

The laws of New York require the following statement appear: Any person who knowingly and with intent lo 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 live thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

Signature of Employee: **This has to be a handwritten signature** Date: _____

After signing please scan and send to tcbenefits@tusculum.edu

Print **Clear Form**

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Fraud Warning Statements

The laws of several states require the following statements lo 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 lines 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, Kansas, Nebraska, Oregon, and Vermont: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto , may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

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

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

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

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, 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.

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.