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

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

Please print clearly and mark carefully.

Employer Name: CHAMBLISS BAHNER & STOPHEL P.C | Group Plan Number: 00513874 | 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 ELIGIBLE EMPLOYEES 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	Social Security Number / Date of Birth	Status
Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		❑ M ❑ F	____-____-____ Date of Birth (mm-dd-yyyy) ____-____-____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	❑ M ❑ F	____-____-____ Date of Birth (mm-dd-yyyy) ____-____-____	Status (check all that apply) ❑ Student (if over age 24) ❑ Disabled ❑ Non standard dependent State of Residence:__________
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	❑ M ❑ F	____-____-____ Date of Birth (mm-dd-yyyy) ____-____-____	Status (check all that apply) ❑ Student (if over age 24) ❑ Disabled ❑ Non standard dependent State of Residence:__________

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 (if over age 24) ❑ Disabled ❑ Non standard dependent State of Residence:________
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 (if over age 24) ❑ Disabled ❑ Non standard dependent State of Residence:________

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:

❑ Basic Life

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

❑ Critical Illness

❑ Accident ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Long Term Disability

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)

Basic Life Coverage:

Benefit reductions apply. Please see plan administrator.

Policy Amount
Employee Only
☑ 100% of your annual salary to a maximum of $100,000
The Guarantee Issue Amount is $100,000.

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.)

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.

LIFE INSURANCE *continued*

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
❑ $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				

Guarantee Issue up to: Employee Less than age 65 $150,000*, 65-69 $50,000, 70+ $10,000. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

❑ 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
❑ $155,000	❑ $160,000	❑ $165,000	❑ $170,000	❑ $175,000	❑ $180,000
❑ $185,000	❑ $190,000	❑ $195,000	❑ $200,000	❑ $205,000	❑ $210,000
❑ $215,000	❑ $220,000	❑ $225,000	❑ $230,000	❑ $235,000	❑ $240,000
❑ $245,000	❑ $250,000				

Guarantee Issue up to: Spouse Less than age 65 $25,000*, 65-69 $10,000, 70+ $0.

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

❑ I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

❑ $2,000	❑ $4,000	❑ $6,000	❑ $8,000	❑ $10,000*

**Guarantee Issue Amount*

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

❑ I do not want this coverage

Add Voluntary AD&D

You must enroll for voluntary term life to be eligible for this coverage. Your elected amount of coverage will be 1 time(s) the coverage elected for voluntary life. You must be enrolled to cover your dependents.

❑ Employee	❑ Spouse	❑ Child(ren)
❑ I do not want this coverage	❑ I do not want this coverage	❑ 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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

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.

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.

Long-Term Disability (LTD) Coverage:

Monthly Benefit

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

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

Benefit reductions apply. Please see plan administrator.

Employee
Insurance Amount: ❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000 ❑ $25,000 ❑ $30,000
❑ $35,000 ❑ $40,000 ❑ $45,000 ❑ $50,000

❑ I do not want this coverage.

Spouse
Insurance Amount: Up to 60% of the employee's amount to a maximum of $30,000

❑ $3,000 ❑ $6,000 ❑ $9,000 ❑ $12,000 ❑ $15,000 ❑ $18,000 ❑ $21,000
❑ $24,000 ❑ $27,000 ❑ $30,000

❑ I do not want this coverage.

Dependent/Child(ren)
Insurance Amount: ❑ 25% of the employee's amount

❑ 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

If you or your dependent spouse elect Critical Illness Coverage and elect an amount above the Guaranteed Issue amount, you must answer the following health questions.

1. Has any proposed insured been diagnosed with or treated by a medical professional for any of the following conditions: cancer, carcinoma in situ,malignant melanoma, tumor (benign or malignant), Barrett's esophagus, Crohn's disease, ulcerative colitis, blood disorder (other than AIDS or HIV), any chronic or progressive disease of kidneys, liver (including hepatitis), lungs, including emphysema and COPD, pancreas or bone marrow? Or, been advised to have an organ transplant, including bone marrow or stem cell transplant?

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

2. Has any proposed insured been diagnosed with or treated by a medical professional for heart attack, heart disease or coronary artery disease, stroke or transient ischemic attack (TIA), or been advised to have bypass surgery, stent insertions or treatment for coronary arteries?

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

3. Has any proposed insured been diagnosed with or treated by a medical professional for uncontrolled blood pressure (requiring a change in medication or dosage in the past 6 months or been diagnosed with or treated for diabetes (except if present only in pregnancy)?

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

4. Has any proposed insured been diagnosed with or treated by a medical professional for any progressive vision, speech or hearing disorder, or dementia (including Alzheimer's disease) or any neurological disease or disorder, including seizures, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), Huntington's disease, Multiple Sclerosis or Parkinson's Disease ?

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

5. Has any proposed insured been diagnosed with or treated by a medical professional for AIDS (acquired immune deficiency syndrome), AIDS-Related Complex or tested positive for HIV (human immunodeficiency virus)?

Employee ❑ Yes ❑ No Spouse ❑ Yes ❑ No

IMPORTANT NOTES:

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

Accident Coverage

You must be enrolled to cover your dependents.

Your Semi-monthly premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
	❑ $8.89	❑ $14.66	❑ $16.05	❑ $21.81

❑ I do not want this coverage.

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.

Signature

- 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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

- 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.
- 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 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 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 00513874, 0001, EN

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.

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.

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.

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.