Guardian Life, P.O. Box 981585,
El Paso, TX 79998-1585

Please print clearly and mark carefully.

Employer Name: **COOPER CONSULTING**	Group Plan Number: **00502341**	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 OTHER ELIGIBLE EMPLOYEES Division: N/A Subtotal Code: N/A **(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: ____-____-____

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. 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 dependent tax exemption. Dependent 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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Jun 28, 2018

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)

☐ Basic Life

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

☐ Long Term Disability

☐ Short Term Disability

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: Managed Dental Care	☐	☐	☐	☐
Option 2: Value	☐	☐	☐	☐
Option 3: NAP	❑	❑	❑	❑

- **If Managed Dental Care is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit guardianlife.com for a list of providers. If you do not select a PCD, one will be assigned for you.**

Employee _____ Spouse _____ Child(ren) _____

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

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

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

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature	☐ $9.43	☐ $15.89	☐ $16.22	☐ $25.65

☐ 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

Guardian Group Plan Number: **00502341**

Please print employee name:

Basic Life Coverage:
Benefit reductions apply. Please see plan administrator.

Policy Amount
Employee Only
☑ 100% of your annual salary to a maximum of $200,000

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.

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***

☐ $25,000	☐ $50,000	☐ $75,000	☐ **$100,000***	☐ $125,000	☐ $150,000
☐ $175,000	☐ $200,000	☐ $225,000	☐ $250,000	☐ $275,000	☐ $300,000
☐ $325,000	☐ $350,000	☐ $375,000	☐ $400,000	☐ $425,000	☐ $450,000
☐ $475,000	☐ $500,000				

*Guarantee Issue Amount. 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 Amount

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

☐ I do not want this coverage

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

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

Policy Amount

☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $4,000 ☐ $5,000 ☐ $6,000
☐ $7,000 ☐ $8,000 ☐ $9,000 ☐ **$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

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.

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.

Short-Term Disability (STD) Coverage:

Weekly Benefit

☑ 60% of salary to a maximum of $2,308

Long-Term Disability (LTD) Coverage:

Monthly Benefit

☑ 60% of salary to a maximum of $10,000

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.

Guardian Group Plan Number: **00502341** Please print employee name:

- 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: 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** _____

Enrollment Kit 00502341, 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.

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.

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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.