GUARDIAN®

Karuk Tribe

Dental Benefit Summary

Group Number: 447691

About Your Benefits:

Good oral hygiene is important, not only for looks, but for general health as well. A routine dental examination can detect many diseases including heart disease, diabetes, anemia, stomach ulcers, osteoporosis and kidney disease. Regular check ups and cleanings can save you the pain and expense of future problems. Using your dental insurance for regular dental check- ups can improve your health. Your dental insurance can also help save you money if more serious dental treatments are needed.

With your **PPO** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist.

	PPO	
Network	DentalGuard Preferred	
Calendar year deductible	*In-Network*	*Out-of-Network*
Individual	$50	$50
Family limit	3 per family	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*
Preventive Care (e.g. cleanings)	100%	100%
Basic Care (e.g. fillings)	80%	80%
Major Care (e.g. crowns, dentures)	50%	50%
Orthodontia	Not Covered	
Annual Maximum Benefit	$1000	$1000
Maximum Rollover	Yes	
Rollover Threshold	$500	
Rollover Amount	$250	
Rollover In-network Amount	$350	
Rollover Account Limit	$1000	
Lifetime Orthodontia Maximum	Not Applicable	
Dependent Age Limits	26	

A Sample of Services Covered by Your Plan:

		PPO *Plan pays (on average)*	
		In-network	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	100%	100%
	Limits:	No Age Limits	
	Oral Exams	100%	100%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Anesthesia*	80%	80%
	Fillings‡	80%	80%
	Perio Surgery	80%	80%
	Periodontal Maintenance	80%	80%
	Frequency:	Once Every 6 Months (Enhanced)	
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%
	Root Canal	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%
	Simple Extractions	80%	80%
	Surgical Extractions	80%	80%
Major Care	Bridges and Dentures	50%	50%
	Dental Implants	50%	50%
	Inlays, Onlays, Veneers**	50%	50%
	Single Crowns	50%	50%

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

Manage Your Benefits:

Enrolled members and their dependents can access helpful, secure information about their Guardian benefits at www.guardiananytime.com

Find A Dentist:

Visit www.GuardianLife.com
Under "Contact Us", Click on "Find A Provider"

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. 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-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3 – DG2000

GUARDIAN®

Vision Benefit Summary

Group Number: 447691

About Your Benefits:

These days, more and more people are making sure they have access to quality vision care. Regular eye exams not only diagnose vision problems, they provide early detection of serious health problems such as diabetes, hypertension, neurological disorders and brain tumors.

Guardian provides rich, flexible vision plans covering exams and materials – making it more affordable to keep your eyes healthy.

Visit any doctor with your **Full Feature** plan, but save by visiting any of the 34,000 locations in the nation's largest vision network.

	Full Feature	
Network	VSP Network Signature Plan	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 25	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $46
Single Vision Lenses	$0	Amount over $47
Lined Bifocal Lenses	$0	Amount over $66
Lined Trifocal Lenses	$0	Amount over $85
Lenticular Lenses	$0	Amount over $125
Frames	80% of amount over $120	Amount over $47
Contact Lenses *(Elective)*	Amount over $120	Amount over $120
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts
Cosmetic Extras	Avg. 30% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price^	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every 12 months	
Lenses *(for glasses or contact lenses)*‡‡	Every 12 months	
Frames	Every 24 months‡‡‡	
Network discounts *(cosmetic extras, glasses and contact lens professional service)*	Limitless within 12 months of exam.	
Dependent Age Limits	26	

‡‡Benefit includes coverage for glasses or contact lenses, not both.

‡‡‡The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.

This is only a partial list of vision services. Your certificate of benefits will show exactly what is covered and excluded.

^ For the discount to apply your purchase must be made within 12 months of the eye exam. In addition Full-Feature plans offer 30% off additional prescription glasses and nonprescription sunglasses, including lens options, if purchased on the same day as the eye exam from the same VSP doctor who provided the exam.

Manage Your Benefits:

Enrolled members and their dependents can access helpful, secure information about their Guardian benefits at www.guardiananytime.com

Find A Vision Provider

Visit www.GuardianLife.com
Under "Contact Us", click on "Find A Provider"

EXCLUSIONS AND LIMITATIONS

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.

Laser Correction Surgery:

On average, 15% off the usual charge or 5% off promotional price for vision laser surgery. Members' out-of-pocket costs are limited to $1,800 per eye for LASIK and $1,500 per eye for PRK.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

Life Benefit Summary

Group Number: 447691

About Your Benefits:

Life insurance provides crucial financial protection for your family if something were to ever happen to you. Benefits can be used towards income replacement, a mortgage, tuition, outstanding debt, and more — allowing you to take care of your loved ones even if you are not there. Better yet, this important coverage is being made available to you at economical group rates. Take advantage and enroll today!

What Your Benefits Cover:

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides $15,000 Basic Term Life coverage for all full time employees.	$10,000 increments to a maximum of $500,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage equal to one times the employee's life benefits.	Please see details on Enhanced Accidental Death and Dismemberment
Spouse/Domestic Partner ‡ Benefit	N/A	50% of employee coverage to a max of $250,000
Child benefit: —children age 14 days to 26 years (26 if full time student) for Voluntary Life	N/A	10% of employee coverage to a max of $10,000. Coverage limits are based on child age.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period**.**	Underwriting may be required, depending on amount and/or age	We Guarantee Issue coverage for enrollees less than age 65 up to $150,000 per employee, $10,000 for a spouse and $10,000 for dependent children
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take your coverage with you if you terminate employment**.**	Yes, with age and other restrictions, including evidence of insurability	Yes, with age and other restrictions, including evidence of insurability
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	No	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits

‡ **Spouse coverage terminates at age 70.**

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style. To help you assess your needs, you can also go to Guardian Anytime and use our Life Insurance Explorer Tool.

Monthly premiums displayed.
Policy Election Cost Per Age Bracket

		< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$10,000 Policy Election Amount											
Employee	$10,000	$.50	$.50	$.60	$.80	$1.40	$2.30	$3.50	$6.00	$10.00	$15.90
Spouse	$5,000	$.25	$.25	$.30	$.40	$.70	$1.15	$1.75	$3.00	$5.00	$7.95
Child	$1,000	$.16	$.16	$.16	$.16	$.16	$.16	$.16	$.16	$.16	$.16
$20,000 Policy Election Amount											
Employee	$20,000	$1.00	$1.00	$1.20	$1.60	$2.80	$4.60	$7.00	$12.00	$20.00	$31.80
Spouse	$10,000	$.50	$.50	$.60	$.80	$1.40	$2.30	$3.50	$6.00	$10.00	$15.90
Child	$2,000	$.32	$.32	$.32	$.32	$.32	$.32	$.32	$.32	$.32	$.32
$30,000 Policy Election Amount											
Employee	$30,000	$1.50	$1.50	$1.80	$2.40	$4.20	$6.90	$10.50	$18.00	$30.00	$47.70
Spouse	$15,000	$.75	$.75	$.90	$1.20	$2.10	$3.45	$5.25	$9.00	$15.00	$23.85
Child	$3,000	$.48	$.48	$.48	$.48	$.48	$.48	$.48	$.48	$.48	$.48
$40,000 Policy Election Amount											
Employee	$40,000	$2.00	$2.00	$2.40	$3.20	$5.60	$9.20	$14.00	$24.00	$40.00	$63.60
Spouse	$20,000	$1.00	$1.00	$1.20	$1.60	$2.80	$4.60	$7.00	$12.00	$20.00	$31.80
Child	$4,000	$.64	$.64	$.64	$.64	$.64	$.64	$.64	$.64	$.64	$.64
$50,000 Policy Election Amount											
Employee	$50,000	$2.50	$2.50	$3.00	$4.00	$7.00	$11.50	$17.50	$30.00	$50.00	$79.50
Spouse	$25,000	$1.25	$1.25	$1.50	$2.00	$3.50	$5.75	$8.75	$15.00	$25.00	$39.75
Child	$5,000	$.80	$.80	$.80	$.80	$.80	$.80	$.80	$.80	$.80	$.80
$60,000 Policy Election Amount											
Employee	$60,000	$3.00	$3.00	$3.60	$4.80	$8.40	$13.80	$21.00	$36.00	$60.00	$95.40
Spouse	$30,000	$1.50	$1.50	$1.80	$2.40	$4.20	$6.90	$10.50	$18.00	$30.00	$47.70
Child	$6,000	$.96	$.96	$.96	$.96	$.96	$.96	$.96	$.96	$.96	$.96
$70,000 Policy Election Amount											
Employee	$70,000	$3.50	$3.50	$4.20	$5.60	$9.80	$16.10	$24.50	$42.00	$70.00	$111.30
Spouse	$35,000	$1.75	$1.75	$2.10	$2.80	$4.90	$8.05	$12.25	$21.00	$35.00	$55.65
Child	$7,000	$1.12	$1.12	$1.12	$1.12	$1.12	$1.12	$1.12	$1.12	$1.12	$1.12
$80,000 Policy Election Amount											
Employee	$80,000	$4.00	$4.00	$4.80	$6.40	$11.20	$18.40	$28.00	$48.00	$80.00	$127.20
Spouse	$40,000	$2.00	$2.00	$2.40	$3.20	$5.60	$9.20	$14.00	$24.00	$40.00	$63.60
Child	$8,000	$1.28	$1.28	$1.28	$1.28	$1.28	$1.28	$1.28	$1.28	$1.28	$1.28
$90,000 Policy Election Amount											
Employee	$90,000	$4.50	$4.50	$5.40	$7.20	$12.60	$20.70	$31.50	$54.00	$90.00	$143.10
Spouse	$45,000	$2.25	$2.25	$2.70	$3.60	$6.30	$10.35	$15.75	$27.00	$45.00	$71.55
Child	$9,000	$1.44	$1.44	$1.44	$1.44	$1.44	$1.44	$1.44	$1.44	$1.44	$1.44
$100,000 Policy Election Amount											
Employee	$100,000	$5.00	$5.00	$6.00	$8.00	$14.00	$23.00	$35.00	$60.00	$100.00	$159.00
Spouse	$50,000	$2.50	$2.50	$3.00	$4.00	$7.00	$11.50	$17.50	$30.00	$50.00	$79.50
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$110,000 Policy Election Amount											
Employee	$110,000	$5.50	$5.50	$6.60	$8.80	$15.40	$25.30	$38.50	$66.00	$110.00	$174.90
Spouse	$55,000	$2.75	$2.75	$3.30	$4.40	$7.70	$12.65	$19.25	$33.00	$55.00	$87.45
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60

Voluntary Life Cost Illustration *continued*

		< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$120,000 Policy Election Amount											
Employee	$120,000	$6.00	$6.00	$7.20	$9.60	$16.80	$27.60	$42.00	$72.00	$120.00	$190.80
Spouse	$60,000	$3.00	$3.00	$3.60	$4.80	$8.40	$13.80	$21.00	$36.00	$60.00	$95.40
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$130,000 Policy Election Amount											
Employee	$130,000	$6.50	$6.50	$7.80	$10.40	$18.20	$29.90	$45.50	$78.00	$130.00	$206.70
Spouse	$65,000	$3.25	$3.25	$3.90	$5.20	$9.10	$14.95	$22.75	$39.00	$65.00	$103.35
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$140,000 Policy Election Amount											
Employee	$140,000	$7.00	$7.00	$8.40	$11.20	$19.60	$32.20	$49.00	$84.00	$140.00	$222.60
Spouse	$70,000	$3.50	$3.50	$4.20	$5.60	$9.80	$16.10	$24.50	$42.00	$70.00	$111.30
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$150,000 Policy Election Amount											
Employee	$150,000	$7.50	$7.50	$9.00	$12.00	$21.00	$34.50	$52.50	$90.00	$150.00	$238.50
Spouse	$75,000	$3.75	$3.75	$4.50	$6.00	$10.50	$17.25	$26.25	$45.00	$75.00	$119.25
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$160,000 Policy Election Amount											
Employee	$160,000	$8.00	$8.00	$9.60	$12.80	$22.40	$36.80	$56.00	$96.00	$160.00	$254.40
Spouse	$80,000	$4.00	$4.00	$4.80	$6.40	$11.20	$18.40	$28.00	$48.00	$80.00	$127.20
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$170,000 Policy Election Amount											
Employee	$170,000	$8.50	$8.50	$10.20	$13.60	$23.80	$39.10	$59.50	$102.00	$170.00	$270.30
Spouse	$85,000	$4.25	$4.25	$5.10	$6.80	$11.90	$19.55	$29.75	$51.00	$85.00	$135.15
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$180,000 Policy Election Amount											
Employee	$180,000	$9.00	$9.00	$10.80	$14.40	$25.20	$41.40	$63.00	$108.00	$180.00	$286.20
Spouse	$90,000	$4.50	$4.50	$5.40	$7.20	$12.60	$20.70	$31.50	$54.00	$90.00	$143.10
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$190,000 Policy Election Amount											
Employee	$190,000	$9.50	$9.50	$11.40	$15.20	$26.60	$43.70	$66.50	$114.00	$190.00	$302.10
Spouse	$95,000	$4.75	$4.75	$5.70	$7.60	$13.30	$21.85	$33.25	$57.00	$95.00	$151.05
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$200,000 Policy Election Amount											
Employee	$200,000	$10.00	$10.00	$12.00	$16.00	$28.00	$46.00	$70.00	$120.00	$200.00	$318.00
Spouse	$100,000	$5.00	$5.00	$6.00	$8.00	$14.00	$23.00	$35.00	$60.00	$100.00	$159.00
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$210,000 Policy Election Amount											
Employee	$210,000	$10.50	$10.50	$12.60	$16.80	$29.40	$48.30	$73.50	$126.00	$210.00	$333.90
Spouse	$105,000	$5.25	$5.25	$6.30	$8.40	$14.70	$24.15	$36.75	$63.00	$105.00	$166.95
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60
$500,000 Policy Election Amount											
Employee	$500,000	$25.00	$25.00	$30.00	$40.00	$70.00	$115.00	$175.00	$300.00	$500.00	$795.00
Spouse	$250,000	$12.50	$12.50	$15.00	$20.00	$35.00	$57.50	$87.50	$150.00	$250.00	$397.50
Child	$10,000	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60	$1.60

Guarantee Issue Amount: Employee $150,000; Spouse $10,000; Child $10,000

Premiums for Voluntary Life Increase in five-year increments

‡Spouse/DP coverage premium is based on Employee age. Coverage for the spouse terminates at spouse's age 70.

†Benefit reductions apply.

Manage Your Benefits:

Enrolled members and their dependents can access helpful, secure information about their Guardian benefits at www.guardiananytime.com

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE AND AD&D COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

Voluntary Life Only:

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-1-R-LB-90, GP-1-R-EOPT-96

Guarantee Issue/Conditional Issue amount applies for ages less than 65. Ages 65-69 maximum issue underwriting amounts $10,000 for employee and $5,000 spouse. Ages 70 and older must be individually underwritten for all amounts.

For AD&D: We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties er on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within 365 days of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

This handout is for illustration purposes only and is an approximation, premium amounts may be amended.

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Accidental Death and Dismemberment Benefit Summary

Group Number: 447691

About Your Benefits:

AD&D coverage provides additional benefits following an accidental death or certain bodily injuries.

What Your Benefits Cover:

Benefit Amounts Available

	$10,000	$20,000	$30,000	$40,000	$50,000	$100,000	$120,000	$150,000	$200,000	$250,000	$300,000
Monthly Premiums* (Estimated premium deduction)											
Employee	$0.40	$0.80	$1.20	$1.60	$2.00	$4.00	$4.80	$6.00	$8.00	$10.00	$12.00
Family	$0.70	$1.40	$2.10	$2.80	$3.50	$7.00	$8.40	$10.50	$14.00	$17.50	$21.00

Additional Benefit Amounts Available

	$350,000	$400,000	$450,000	$500,000
Monthly Premiums* (Estimated premium deduction)				
Employee	$14.00	$16.00	$18.00	$20.00
Family	$24.50	$28.00	$31.50	$35.00

Benefit Payments for family coverage vary based on the family structure at the time of claim.

Employee & Spouse	Spouse benefit is 60% of employee amount
Employee & Child(ren)	Child (ren) benefit is 20% of employee amount
Employee, Spouse & Child(ren)	Spouse benefit is 40% and Child(ren) is 10% of employee amount
	Spouse coverage terminates at age 70.

Benefit Reductions—Please be aware that your Benefit Amount may decrease as shown below:

Applicable to Your Supplemental Coverage	35 % at Age 65
	60 % at Age 70
	75 % at Age 75
	85 % at Age 80

Enhanced AD&D Features Include: Child Education Benefit, Education & Retraining Benefit, Seatbelt & Airbag Benefit, Day Care Expense, Repatriation, and Common Carrier.

Manage Your Benefits:

Enrolled members and their dependents can access helpful, secure information about their Guardian benefits at www.guardiananytime.com

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATION AND EXCLUSIONS FOR AD&D:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties er on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al . We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within 365 days of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

A loss may be defined as death, quadriplegia, loss of speech and hearing, loss of cognitive function, comatose state in excess of one month, hemiplegia or paraplegia. The loss must occur within 365 days of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

This handout is for illustration purposes only and is an approximation, premium amounts may be amended..

ADDITIONAL MATERIALS

Finding a dentist or vision care provider is easy

Go online – it just takes minutes!

The best way to save money through your dental or vision plan is by seeing a provider in your plan's network. Guardian's Find a Provider site makes it easy for you to search for a dental or vision provider meets your needs.

Guardian's Find a Provider site is available to you 24 hours a day, 7 days a week.

Here are just a few things you can do online:

- Customize your search by specialty, languages spoken and more
- Get side-by-side comparisons of provider information (ie. office status, distance)
- Create a quick-list of "favorite" providers — for easy reference online
- Get maps and directions to a providers office location
- View your results online or have them faxed or emailed to you
- Save your search criteria for easy access when you revisit the site
- Create a customized provider directory
- Nominate a dentist to be included in a network

Just go to www.GuardianAnytime.com and click on "Find a Provider". You can also find a provider on the go from your smart phone – simply download our app.

Dental Care Information Now at Your Fingertips

Introducing new online tools, for Guardian members, to help you take better care of your oral and overall health, available at www.GuardianAnytime.com (see the My Benefits tab)

Estimate the cost of your dental care

- View estimates for out-of-pocket costs prior to receiving the actual treatment
- See the estimated cost savings if you use a Guardian network provider
- Access a dental glossary for definitions of key dental terms

Read about tips for a Healthy Smile

- Learn more about how to maintain good oral health and its impact on their overall health and well-being
- Topics include tips on getting the right care, children's dental care, prevention and recognizing dental problems

Find a dentist quickly and easily

- Create a customized list of providers based on their preferences, or look up a specific provider
- Unique features include side-by-side comparisons of provider information, ability to create a short list of "favorite" providers for quick reference and get maps and directions to an office
- Have your results faxed or emailed back to you

Maximum Rollover®

Save Your Dental Annual Maximum Dollars For a Time When You Need Them Most!

With Maximum Rollover, Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). The MRA can be used in further years, if you reach the plan's annual maximum.

To qualify, you must submit a claim for covered services for which a benefit payment is issued, in excess of any deductible or co-pay, and you must not exceed the paid claims threshold during the benefit year.

You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

PLAN ANNUAL MAXIMUM **	THRESHOLD	MAXIMUM ROLLOVER AMOUNT	IN-NETWORK ONLY MAXIMUM ROLLOVER AMOUNT	MAXIMUM ROLLOVER ACCOUNT LIMIT
$1000	$500	$250	$350	$1000

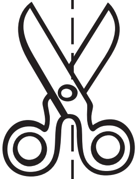
** If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

NOTES:

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2009, the claim activity in 2010 will be used and applied to MRAs for use in 2011.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year.

Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year.



DentalGuard Preferred Dentist Nomination Form

I would like to nominate my dentist for inclusion in the DentalGuard Preferred Provider Network. I understand that my name may be used when contacting my dentist to inform him/her of my desire for them to join the network. For more information, visit us online at www.GuardianLife.com.

DATE: ______________________

Employer: ______________________

Patient: ______________________

Address: ______________________

City/State/Zip: ______________________

Phone: ______________________

Fax: ______________________

E-mail: ______________________

DENTIST INFO

Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Phone: ______________________

Specialty: ______________________

Please submit completed form to:

Guardian
DentalGuard Preferred
P.O. Box 2465
Spokane, WA 99210-9817

or FAX to: 509-468-6550

Your Confidential Employee Assistance Program

WorkLifeMatters

Providing Assistance for What Matters Most
Let's face it, balancing your work and home life is not easy. With WorkLifeMatters, your confidential employee assistance program, you don't have to face life challenges alone. WorkLifeMatters provides guidance for personal issues that you might be facing and information about other concerns that affect your life.

WorkLifeMatters can offer help with:

Education
- ✓ Admissions testing & procedures
- ✓ Adult re-entry programs
- ✓ College Planning
- ✓ Financial aid resources
- ✓ Finding a pre-school

Dependent Care & Care Giving
- ✓ Adoption Assistance
- ✓ Before/after school programs
- ✓ Day Care/Elder Care
- ✓ Elder care
- ✓ In-home services

Legal and financial
- ✓ Basic tax planning
- ✓ Credit & collections
- ✓ Debt Counseling
- ✓ Home buying
- ✓ Immigration

Lifestyle & Fitness Management
- ✓ Anxiety & depression
- ✓ Divorce & separation
- ✓ Drugs & alcohol

Working Smarter
- ✓ Career development
- ✓ Effective managing
- ✓ Relocation

…Support is a phone call or click away
- o Unlimited free telephonic consultation with an EAP counselor available 24/7 at 800-386-7055
- o Referrals to local counselors - up to three sessions free of charge
- o State of the art website featuring over 3,400 helpful articles and topics like wellness, training courses, and a legal and financial center: www.ibhworklife.com; User Name: Matters; Password: wlm70101

WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters Program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters Program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-541-7846 for Dental. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer los documentos y puede que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-800-541-7846 para servicios odontológicos. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-541-7846 for Dental. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-800-541-7846 para servicios odontológicos. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-541-7846 لخدمات طب الأسنان. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-800-541-7846 համարով Ատամնաբուժության համար: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，牙科協助請致電 1-800-541-7846 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Traditional Chinese

Cov Kev Pab Txhais Lus Tsis them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-541-7846 rau Kev Kho Hniav. Yog xav tau kev pab ntxiv hu rau Ca lub Caij Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357. Hmong

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-800-541-7846（歯科用）までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-800-541-7846 សម្រាប់ខាងធ្មេញ ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ាតាមលេខ 1-800-927-4357 Khmer

무료 통역 서비스. 귀하는 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 치과 서비스 1-800-541-7846 번으로 문의해주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내전화 1-800-927-4357 번으로 연락해 주십시오. Korean

خدمات مجاني مربوط به زبان. شما ميتوانيد از خدمات يك مترجم شفاهي استفاده كنيد و بگوئيد مدارك به زبا فارسي برايتان خوانده شوند. براي دريافت كمك، با ما از طريق شماره تلفني كه روي كارت شناسائي شما قيد شده است و يا شماره 1-800-541-7846 براي دندانپزشكي تماس بگيريد. براي دريافت كمك بيشتر به CA Dep. of Insurance (اداره بيمه كاليفرنيا) به شماره 1-800-927-4357 تلفن كنيد. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ ਦੰਦਾਂ ਲਈ 1-800-541-7846'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-800-541-7846 (стоматологическая страховка). Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-541-7846 para sa Dental. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc gọi số 1-800-541-7846 cho dịch vụ nha khoa. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

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

Home Address

Employee's Social Security Number	Home Phone Number	Cell Phone Number	Date of Marriage	Employee's Place of Birth (State)

Email Address	How Best toContact
Amount In Force	Amount Being Requested

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

Question	Answer
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. (a) Ever been treated for or diagnosed as having HIV (Human Immunodeficiency Virus)? (b) In the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); lymphadenopathy (enlarged or swollen glands)?	**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

Optional Life: $ Guardian's Universal Life: $

Spouse: ☐ Approved ☐ Declined Premium Class: ☐ Preferred ☐ Standard

Optional Life: $ Spouse Term Rider: $

Child: ☐ Approved ☐ Declined

Optional Life: $ Child Term Rider: $

Excess Life $_______ ☐ Approved ☐ Declined
Long Term Disability $_______ ☐ Approved ☐ Declined
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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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.

*** 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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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.

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Please print clearly to ensure accurate processing

Employer:
Karuk Tribe
64236 Second Ave
Happy Camp, CA 96039

Guardian Group Plan Number: **447691**

The Guardian Life Insurance Company of America

EMPLOYER USE ONLY ❑ New Application ❑ Add Dependent(s) ❑ Drop Dependent(s) ❑ Change Address
❑ Change Name ❑ Drop Coverage as of: / /

Class	Hours Worked	Division	Benefits Effective
All Eligible Employees			/ /

Keep a copy for your records and return form to: **Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012**

ABOUT YOURSELF

Print clearly in black or blue ink.

First, Middle Initial, Last Name ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -

Address	City	State	Zip

Preferred E-mail	Day Phone	Eve Phone	The best way to reach you: ❑ E-mail ❑ Day Phone ❑ Eve Phone

Job Title	Work Status ❑ Full-Time ❑ Part-Time ❑ Retired ❑ COBRA/State Continuation	Date work status began / /	Annual Salary/Earnings $

Are you married? ❑ Yes ❑ No If you have a domestic partner (DP), is your partnership registered with the State of California? ❑ Yes ❑ No

Do you have children or other dependents? ❑ Yes ❑ No

ABOUT YOUR DEPENDENTS

❑ A sheet with information about additional dependents is attached.

Spouse/DP First, Middle Initial, Last Name ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Marriage Date (mm/dd/yyyy) / /	
Child 1 ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 2 ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 3 ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 4 ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /

To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages.
❑ Basic Life ❑ Voluntary Life ❑ AD&D ❑ Dental ❑ Vision

YOUR BASIC LIFE COVERAGE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

	Policy Amount
Employee	☑ $15,000

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy $ _______

CEF2005

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Jul 25, 2013

LIFE INSURANCE *continued*

Name your beneficiaries		Primary beneficiaries must total 100%.
Primary Beneficiary 1 First, Middle Initial, Last Name	Relationship to Employee	Percent %
Primary Beneficiary 2		%
Contingent Beneficiary		%

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

CHOOSE YOUR VOLUNTARY TERM LIFE COVERAGE

Check one box only

Employee

Policy Amount — You must be enrolled to cover your dependents.

❑ $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	❑ $500,000		

$_____________

**Guarantee Issue Amount*

❑ I waive this coverage

Add Voluntary Life for Spouse/DP — *Check one box only*

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

❑ I waive this coverage

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

Add Voluntary Life for Child(ren) — *Check one box only*

❑ 10% of employee's amount to maximum $10,000

❑ I waive this coverage

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

❑ A separate sheet for Voluntary Term Life beneficiaries is attached if they are not the same as those named for Basic Life.

For Voluntary Life, an Evidence of Insurability form must be completed for any amount above the Guarantee Issue.

IMPORTANT NOTES

- If you waive life or disability coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian reserves the right to reject your request.
- Children will not be covered until they reach 14 days.
- Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Voluntary Life and/or Guardian Universal Life.

CHOOSE ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

Check one box only

	Policy Amount				
Employee	❑ $10,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000
	❑ $100,000	❑ $120,000	❑ $150,000	❑ $200,000	❑ $250,000
	❑ $300,000	❑ $350,000	❑ $400,000	❑ $450,000	❑ $500,000
❑ I waive this coverage					
Add Entire Family (includes Employee, Spouse/DP and Child(ren))	❑ $10,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000
	❑ $100,000	❑ $120,000	❑ $150,000	❑ $200,000	❑ $250,000
	❑ $300,000	❑ $350,000	❑ $400,000	❑ $450,000	❑ $500,000
❑ I waive this coverage					

You must be enrolled to cover your dependents.

CHOOSE YOUR DENTAL COVERAGE

Check one box only

	PPO			
Employee alone	❑			❑ I waive this coverage
Employee and Spouse/DP	❑			❑ I waive this coverage
Employee and Child(ren)	❑			❑ I waive this coverage
Entire family	❑			❑ I waive this coverage

If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.

Reason for Loss of coverage: ❑ Termination of Employment ❑ Divorce ❑ Death of Spouse/DP ❑ Termination or Expiration of coverage	Date of coverage loss / /
If you are waiving coverage, are you covered under another dental plan? ❑ Yes ❑ No	If you are waiving dependent coverage, are your dependents covered under another dental plan? ❑ Yes ❑ No

IMPORTANT NOTES

- Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse/DP, divorce or where a court has ordered coverage be provided for an eligible spouse/DP or eligible children, provided you apply within 30 days.

CHOOSE YOUR VISION COVERAGE

Check one box only

	Full Feature			
Employee alone	❑			❑ I waive this coverage
Employee and Spouse/DP	❑			❑ I waive this coverage
Employee and Child(ren)	❑			❑ I waive this coverage
Entire family	❑			❑ I waive this coverage

If you are waiving coverage, are you covered under another vision plan? ❑ Yes ❑ No	If you are waiving dependent coverage, are your dependents covered under another vision plan? ❑ Yes ❑ No

IMPORTANT NOTES

- If I have waived the vision coverage, and elect coverage at a later date, enrollment delays may apply.
- Your plan includes a One Year Lock-In/Lock-Out Provision - Your election to enroll in or waive vision coverage must remain in effect until your plan's next annual vision enrollment period.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

SIGNATURE

- 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 understand that I must be actively at work or my life and/or disability coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
- 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 agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- I understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
- **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 may be guilty of insurance fraud.**

SIGNATURE OF EMPLOYEE X ______________________ **DATE** __________