Guardian

BENESCH FRIEDLANDER COPLAN & ARONOFF LLP
ALL ELIGIBLE EMPLOYEES
Group Number: 00481071

Customer Service (888) 600-1600
Monday to Friday | 8am to 8:30pm ET

Welcome to
Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1. Read through this information.
2. Find out more about your benefits.
3. Talk to your employer if you need help or have any questions.

Your coverage options

Critical illness insurance	Taking care of the expenses if you're critically ill

This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

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Watch our video
How critical illness insurance helps cover the costs of treatment.

Critical illness insurance

Critical illness insurance may help you cover expenses not covered by your health insurance.

It's a cash payment you receive if you ever experience a serious illness like cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery.

Who is it for?

Critical illness insurance is a supplemental policy for people who already have health insurance. It provides you with an additional payment to cover expenses like deductibles, treatments, and living costs.

What does it cover?

Critical illnesses include strokes, heart attacks, Parkinson's disease and cancer. Our policies can cover over 30 major illnesses, helping you stay financially stable by paying you a lump sum if you're diagnosed with one of them.

Why should I consider it?

Health coverage is becoming more expensive, with higher co-pays, premiums, and deductibles. Critical illness insurance is an affordable way to supplement and pay for additional expenses that your health insurance doesn't cover. Our policies typically provide payments for the first and second time you're diagnosed with a covered illness.

Plus, critical illness insurance is portable and payments are made directly to you.

Critical costs

John is hospitalized after a heart attack, and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **$53,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **$10,300**.

Total out-of-pocket amount for John (deductible + coinsurance): **$11,800**.

John has a **$10,000** Guardian Critical Illness policy, which covers the majority of these out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

You will receive these benefits if you meet the conditions listed in the policy.

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Your critical illness coverage

	CRITICAL ILLNESS	
Benefit Amount(s)	Employee may choose a lump sum benefit of $10,000 to $30,000 in $10,000 increments.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	100%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	100%
Stroke	100%	100%
Heart Failure	100%	100%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	100%
Kidney Failure	100%	100%
ADDITIONAL CONDITIONS	**1st OCCURRENCE ONLY**	
Addison's Disease	30%	
ALS (Lou Gehrig's Disease)	100%	
Alzheimer's Disease	50%	
Coma	100%	
Huntington's Disease	30%	
Loss of Hearing	100%	
Loss of Sight	100%	
Loss of Speech	100%	
Multiple Sclerosis	30%	
Parkinson's Disease	100%	
Permanent Paralysis	50% for 1 limb, 100% for 2 limbs	
Severe Burns	100%	
Childhood Conditions	**1st OCCURRENCE ONLY**	
Cerebral Palsy	100%	
Cleft Lip/Palate	100%	
Club Foot	100%	
Cystic Fibrosis	100%	
Down's Syndrome	100%	
Muscular Dystrophy	100%	
Spina Bifida	100%	
Type 1 Diabetes	100%	

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Your critical illness coverage

	CRITICAL ILLNESS
Spouse Benefit	50% of employee's lump sum benefit
Child Benefit- children age Birth to 26 years	50% of employee's lump sum benefit
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 or the annual open enrollment period.	We Guarantee Issue up to: $30,000 For a spouse: $15,000 For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue.**
Portability: Allows you to take your Critical Illness coverage with you if you terminate employment.	Included
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	Not Applicable
WELLNESS BENEFIT	
Employee Per Year Limit	$50
Spouse Per Year Limit	$50
Child Per Year Limit	$50

Condition Definitions

- Stroke: Stroke must be severe enough to cause neurological deficits at least 30 days after the event.
- Heart Failure: An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- Organ Failure: Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- Kidney Failure: An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

Critical Illness Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Critical Illness.

Spouse coverage premium is based on Employee age

Child cost is included with employee election.

	Semi-monthly Premiums Displayed *Election Cost Per Age Bracket*					
	< 30	*30-39*	*40-49*	*50-59*	*60-69*	*70+*
$10,000 Benefit Amount						
Employee $10,000	$2.10	$3.15	$5.85	$11.55	$16.10	$22.45
Spouse $5,000	$1.05	$1.58	$2.93	$5.78	$8.05	$11.23
$20,000 Benefit Amount						
Employee $20,000	$4.20	$6.30	$11.70	$23.10	$32.20	$44.90
Spouse $10,000	$2.10	$3.15	$5.85	$11.55	$16.10	$22.45
$30,000 Benefit Amount						
Employee $30,000	$6.30	$9.45	$17.55	$34.65	$48.30	$67.35
Spouse $15,000	$3.15	$4.73	$8.78	$17.33	$24.15	$33.68

EXCLUSIONS AND LIMITATIONS

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR CRITICAL ILLNESS:

We will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category. We will not pay benefits for a Second occurrence (recurrence) of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 12 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

We do not pay benefits for claims relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane.

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 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

Guardian's Critical Illness plan does not provide comprehensive medical coverage. It is a basic or limited benefit and is not intended to cover all medical expenses. It does not provide "basic hospital," "basic medical," or " medical" insurance as defined by the New York State Insurance Department.

Health questions are required on late enrollees. This coverage will not be effective until approved by a Guardian underwriter.

This policy will not pay for a diagnosis of a listed critical illness that is made before the insured's Critical Illness effective date with Guardian.

The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. See your certificate booklet for a full listing of exclusions & limitations..

If Critical Illness insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits..

Contract # GP-1-CI-14

Guardian's Critical Illness Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.
Policy Form # GP-1-LAH-12R; GP-1-CI-14

Employee Assistance Program

We all need a little support every now and then.

Guardian's Employee Assistance Program gives you and your family members access to confidential personal support, across everything from stress management and nutrition to handling legal or financial issues.

The services available include consultations with experienced professionals, as well as access to resources and discounts designed to help you in a variety of different ways.

How it can help

Consultative services are available to provide direct support and assistance

Work/life assistance that can help you save money and balance commitments

Access legal and financial assistance and resources – including WillPrep Services

How to access

Visit
worklife.uprisehealth.com

Access Code
worklife

Call
1 800 386 7055

24 hour crisis help available.
Regular office hours:
Monday-Friday 6am-5pm PST.

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

Legal/financial assistance and resources services are not available in the state of New York.

The Employee Assistance Program is a suite of services solely created and offered by Integrated Behavioral Health, Inc. (IBH), doing business as Uprise Health. Guardian is not responsible or liable for care or advice given by any provider or any service offering within the Employee Assistance Program. This information is for informational purposes only. It is not a contract. Only the plan service agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the Employee Assistance Program at any time without notice. Legal services provided through the Employee Assistance Program will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer. The Employee Assistance Program, or any individual service offering within the Program, is not an insurance benefit and may not be available in all states.

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Guardian®

Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

Important information

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.
Visit **https://www.guardiananytime.com/notice48** to read more.

No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.
Visit **https://www.guardiananytime.com/notice46** to read more.

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

Please print clearly and mark carefully.

Employer/Planholder Name: BENESCH FRIEDLANDER COPLAN & ARONOFF LLP	Group Plan Number: 00481071	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Add Employee/Member Dependents/Family Members ❑ Drop/Refuse Coverage ❑ Information Change

In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term , and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.

Class: ALL ELIGIBLE EMPLOYEES Division:_____ Subtotal Code:_____ (Please obtain this from your Employer/Planholder)

About You:

Full Legal Name-First, MI, Last Name:

What is the name you go by? (optional)

Employer/Planholder Provided Identification:

_____

Social Security Number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.

Address	City	State	Zip

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

Phone (indicate primary): ❑ Home (____) ____ - ____
❑ Work (____) ____ - ____
❑ Mobile (____) ____ - ____

Email Address (indicate primary) ❑ Home _____ ❑ Work _____

Are you married or in a civil union? ❑ Yes ❑ No Date of marriage/civil union:____-____-_____
Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-_____

About Your Job:

Job Title:

Work Status:
❑ Active ❑ Retired ❑ COBRA/State Continuation
Hours worked per week: _____

Date of full time hire: _____ - _____ - _____

About Your Family:

Please include the names of the Dependents/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.

If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.

Spouse Address/City/State/Zip: Phone: ( ) -	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Oct 18, 2023

Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____

Drop Coverage:

❑ Drop Employee/Member ❑ Drop Dependents/Family Members

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 Term Life

❑ Voluntary Term Life

❑ Critical Illness

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)

Critical Illness Coverage:

You must be enrolled to cover your dependents/family members

Benefit reductions apply. Please see plan administrator.

Employee/Member

Insurance Amount: ❑ $10,000 ❑ $20,000 ❑ $30,000

❑ I do not want this coverage.

Spouse

Insurance Amount: ❑ 50% of the employee/member's amount

❑ I do not want this coverage.

Dependent/Child(ren)

Insurance Amount: ❑ 50% of the employee/member's amount

❑ I do not want this coverage.

Employee/Member Only - Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records

Primary Beneficiaries:

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

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

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

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

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

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

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

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

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

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

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

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ❑ Yes ❑ No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:
Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): ____ ____ ____ ____ ____-____ _____ ____
Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____
Phone: ( ) -

Signature

- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- **I attest that the information provided above is true and correct to the best of my knowledge.**

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SIGNATURE OF EMPLOYEE/MEMBER X _____ DATE _____

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

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

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

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

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

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.

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 OF 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.

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.

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.