



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.

Your coverage options



Dental insurance

Taking care of teeth and overall health



Vision insurance

Looking after your eyesight and related health issues

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.

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Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

Why should I consider it?

Poor oral health isn't just aesthetic, it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.

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



Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

Cardiovascular disease: Some research suggests that heart disease, clogged arteries, and infections may be linked to inflammation and infections from oral bacteria.

Osteoporosis: Weak and brittle bones may be linked to tooth loss.

Diabetes: Research shows that people with gum disease find it more difficult to control their blood sugar levels.

Alzheimer's disease: Tooth loss before the age of 35 may be a risk factor for Alzheimer's disease.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2018.



Your dental coverage

PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	PPO	
Your Network is	DentalGuard Preferred	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$50
Family limit	3 per family	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	100%
Basic Care	80%	80%
Major Care	50%	50%
Orthodontia	50%	50%
Annual Maximum Benefit	\$1500	
Maximum Rollover	Yes	
Rollover Threshold	\$700	
Rollover Amount	\$350	
Rollover In-network Amount	\$500	
Rollover Account Limit	\$1250	
Lifetime Orthodontia Maximum	\$1000	
Dependent Age Limits	26	



Your dental coverage

A Sample of Services Covered by Your Plan:

		PPO	
		<i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 19	
	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	
	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%
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%
	Single Crowns	50%	50%
Orthodontia	Orthodontia	50%	50%
	Limits:	Child(ren)	

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 filling 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. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.



Your dental coverage

Manage Your Benefits:

Go to www.Guardianlife.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

Find A Dentist:

Visit www.Guardianlife.com
Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00484482

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date. Please note, self-serve options over the phone or online at Guardian Anytime are not available until the case is fully implemented, please wait to speak to a live agent when calling the Guardian Helpline.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network 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-I-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

DentalGuard 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 DENTAL insurance only.
Policy Form # GP-1-DG2000, et al, GP-1-DEN-16

Oral Health Rewards Program

Regular visits to the dentist can help prevent and detect the early signs of serious diseases.

That's why Guardian's Maximum Rollover Oral Health Rewards Program encourages and rewards members who visit the dentist, by rolling over part of your unused annual maximum into a Maximum Rollover Account (MRA). This can be used in future years if your plan's annual maximum is reached.

How maximum rollover works*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	In-network only rollover amount	Maximum rollover account limit
\$1,500 Maximum claims reimbursement	\$700 Claims amount that determines rollover eligibility	\$350 Additional dollars added to a plan's annual maximum for future years	\$500 Additional dollars added if only in-network providers were used during the benefit year	\$1,250 The limit that cannot be exceeded within the maximum rollover account



Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

* This example has been created for illustrative purposes only.

** 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. May not be available in all states.

Guardian's Dental 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. Information provided in this communication is for informational purposes only. Dental Policy Form No. GP-1-DEN-16. GUARDIAN® is a registered service mark of The Guardian Life Insurance Company of America © Copyright 2019 The Guardian Life Insurance Company of America.

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Vision insurance

Vision insurance helps protect the health of your eyes by providing coverage for benefits that often aren't covered by regular medical insurance.

Protecting your eyesight means allowing for routine visits to the optometrist for eye exams, as well as coverage for glasses and contacts. Make sure your eyes remain in great shape at any age – no matter how much time you spend staring at digital screens.

Who is it for?

Even if you have perfect eyesight, it's important to have regular eye exams to make sure you're still seeing clearly. Most of us may eventually need vision correction, which is why we offer vision insurance to cover some of the costs.

What does it cover?

Vision insurance covers benefits not typically included in medical insurance plans. It covers things like routine eye exams, allowances towards the purchase of eyeglasses and contact lenses, as well as discounts on corrective Lasik surgery.

Why should I consider it?

Regular eye exams can detect more than failing eyesight, they can also pick up diseases like glaucoma and diabetes. Vision problems are one of the most prevalent disabilities in the United States, making vision insurance especially useful for anyone who regularly needs to purchase eyeglasses or contacts, or anyone who simply wants to help protect their eyesight and general health.

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



20/20 coverage

David notices that his vision is deteriorating. He goes in for an eye exam, and is diagnosed with myopia, which means he needs glasses.

Average cost of vision exam: **\$171**

Average cost of frames and lenses: **\$350**

Total cost: **\$521**

With a Vision policy from Guardian, David pays just **\$10** for his eye exam. After **\$25** in copay, his lenses are fully covered, and he pays **\$96** for his frames.

David's total out-of-pocket expense is **\$131**, saving him **\$390**.

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.



Your vision coverage

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of VSP's network locations, including one of the largest private practice provider networks, Visionworks and contracted Pearle Vision locations.

Your Vision Plan	Full Feature	
Your Network is	VSP Choice Network	
Copay		
Exams Copay	\$ 10	
Materials Copay (<i>waived for elective contact lenses</i>)	\$ 25	
Sample of Covered Services	<i>You pay (after copay if applicable):</i>	
	<i>In-network</i>	<i>Out-of-network</i>
Eye Exams	\$0	Amount over \$59
Single Vision Lenses	\$0	Amount over \$30
Lined Bifocal Lenses	\$0	Amount over \$50
Lined Trifocal Lenses	\$0	Amount over \$65
Lenticular Lenses	\$0	Amount over \$100
Frames	80% of amount over \$150 ¹	Amount over \$70
Costco, Walmart and Sam's Club Frame Allowance	Amount over \$0	
Contact Lenses (<i>Elective</i>)	Amount over \$130	Amount over \$120
Contact Lenses (<i>Medically Necessary</i>)	\$0	Amount over \$210
Contact Lenses (<i>Evaluation and fitting</i>)	Up to \$60	Not Applicable
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses (<i>Additional pair of frames and lenses</i>)	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 calendar year	
Lenses (<i>for glasses or contact lenses</i>) ^{‡‡}	Every calendar year	
Frames	Every two calendar years ^{‡‡‡}	
Network discounts (<i>glasses and contact lens professional service</i>)	Limitless within 12 months of exam.	
Dependent Age Limits	26	
To Find a Provider:	Register at VSP.com to find a participating provider.	

VSP

- Covered in full lens options (In Network Only): Scratch Resistant Coating
- Additional Features Benefits: Diabetic Eyecare
- ^{‡‡}Benefit includes coverage for glasses or contact lenses, not both.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.
- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.



Your vision coverage

- ¹Extra \$20 on select brands
- Members can use their in network benefits on line at Eyeconic.com.
- ~~###~~ 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.
- In Network Routine Retinal Screening Covered after no more than a \$39 copay.

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- I -VSN-96-VIS et al.

Laser Correction Surgery:

Discounts on average of 10-20% off usual and customary charge or 5% off promotional price for vision laser Surgery. Members out-of-pocket costs are limited to \$1,800 per eye for LASIK or \$1,500 per eye for PRK or \$2300 per eye for Custom LASIK, Custom PRK, or Bladeless LASIK.

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.

Guardian's Vision 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. 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 Department of Financial Services. Plan documents are the final arbiter of coverage. Policy Form # GP- I -GVSN- I 7

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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.

Vision insurance



Guardian's HIPAA Notice of Privacy Practices

The notice describes how health information about you may be used and disclosed and how you can access this information.

Visit <https://www.guardiananytime.com/notice50> 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: MAMMOTH ENERGY SERVICES	Group Plan Number: 00484482	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Employee/Member Dependents/Family Members <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		
<p>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.</p>		

Class: _____ 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: <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth (mm-dd-yy): ____ - ____ - ____	
Phone (indicate primary): <input type="checkbox"/> Home (____) ____ - ____ <input type="checkbox"/> Work (____) ____ - ____ <input type="checkbox"/> Mobile (____) ____ - ____			
E mail Address (indicate primary) <input type="checkbox"/> Home _____ <input type="checkbox"/> Work _____			
Are you married or in a civil union? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of marriage/civil union: ____ - ____ - ____	
Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No		Placement date of adopted child: ____ - ____ - ____	

About Your Job:	Job Title: _____
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> 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 grandchild, a niece or a nephew.

Spouse (wherever the term "Spouse" appears on this form, it also includes "Civil Union Partner").		Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____	
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: () -				
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: () -				
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: () -				
Child/Dependent 3:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: () -				
Child/Dependent 4:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: () -				

<p>Drop Coverage:</p> <p><input type="checkbox"/> Drop Employee/Member <input type="checkbox"/> Drop Dependents/Family Members</p> <p>The date of withdrawal cannot be prior to the date this form is completed and signed.</p> <p>Last Day of Coverage: ____ - ____ - ____</p> <p><input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement</p> <p>Last Day Worked: ____ - ____ - ____</p> <p><input type="checkbox"/> Other Event: _____</p> <p>Date of Event: ____ - ____ - ____</p>	<p>Coverage Being Dropped:</p> <p><input type="checkbox"/> Dental <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Vision <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p>
<p>Loss Of Other Coverage:</p> <p>I and/or my dependents were previously covered under Loss of coverage was due to:</p> <p><input type="checkbox"/> Termination of Employment: ____ - ____ - ____</p> <p><input type="checkbox"/> Divorce/Separation ____ - ____ - ____</p> <p><input type="checkbox"/> Death of Spouse ____ - ____ - ____</p> <p><input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____</p> <p>Coverage Lost <input type="checkbox"/> Dental <input type="checkbox"/> Vision</p>	<p>I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:</p> <p><input type="checkbox"/> Covered under another insurance plan</p> <p><input type="checkbox"/> Other _____</p> <p>(additional information may be required)</p>

<p>Dental Coverage: You must be enrolled to cover your dependents/family members. Check only one box.</p> <p>Employee/Member Only Employee/Member, Spouse & Dependent/Child(ren)</p> <p>PPO <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> I do not want Dental Coverage because (Check as applicable):</p> <p><input type="checkbox"/> I am covered under another Dental plan</p> <p><input type="checkbox"/> My spouse is covered under another Dental plan</p> <p><input type="checkbox"/> My dependents/family members are covered under another Dental plan</p>

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

	Employee/Member Only	Employee/Member, Spouse & Dependent/Child(ren)
Full Feature	<input type="checkbox"/>	<input type="checkbox"/>

I do not want this Vision coverage because (Check as applicable):

- I am covered under another Vision plan
- My spouse is covered under another Vision plan
- My dependents/family members are covered under another Vision plan

Signature

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- 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.
- 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.

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

SIGNATURE OF EMPLOYEE/MEMBER X _____

SIGNATURE OF SPOUSE X _____ DATE _____

SIGNATURE OF CHILD (IF AGE 18 OR OVER) X _____ DATE _____

SIGNATURE OF CHILD (IF AGE 18 OR OVER) X _____ DATE _____

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.

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.

Oklahoma: WARNING: Any person who knowingly, and with the 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.

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.