

**LIFE INSURANCE** *continued*

**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 deceased, 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**

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- LIFE ONLY: I understand that life insurance coverage for a dependent/family member, other than a newborn child, will not take effect if that dependent/family member is confined to a hospital or other health care facility, or is home confined, or is unable to perform two or more Activities of Daily Living (ADL's).
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet). This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- 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.