Employer:
**SOUTHEASTERN UNIVERSITY**
**1000 LONGFELLOW BLVD**
**LAKELAND, FL 33801**

Guardian Group Plan Number: **382194**

**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 | Do you have children or other dependents? ❑ Yes ❑ No |
|---|---|

## ABOUT YOUR DEPENDENTS

❑ A sheet with information about additional dependents is attached.

| Spouse First, Middle Initial, Last Name ❑ Add ❑ Change ❑ Drop | Sex ❑ M ❑ F | Date of Birth (mm/dd/yyyy) / / | Social Security Number - - | Marriage Date / / | |
|---|---|---|---|---|---|
| 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 ❑ Long Term Disability ❑ Vision

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

| | Policy Amount |
|---|---|
| Employee | ☑ $10,000 |

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



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***DATE FORM PUBLISHED: Feb 22, 2008***

## 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 WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) *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 | ❑ $300,000 | | |

**Guarantee Issue Amount*

***Guarantee Issue Amount plus Additional Amount*
*Note: You must answer additional health questions and complete Evidence of Insurability if necessary to qualify for this policy amount.*

❑ I waive this coverage

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

❑ 50% of employee's amount to maximum $150,000

❑ 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, you must answer the following question if you are choosing an amount over the guarantee issue.**

- In the last 6 months, have you or any of your dependents: (a) tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex or AIDS caused by the HIV infection or other sickness or condition derived from such infection? (b) received medical treatment, consultation, care or services, including diagnostic measures or took prescribed drugs for: cardiovascular disease; cancer; or any other life threatening condition?

Employee: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No Child(ren): ❑ Yes ❑ No

**For Voluntary Life, an Evidence of Insurability form must be completed for any person with a "yes" answer to any of the above questions.**

## 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 YOUR LONG-TERM DISABILITY (LTD) COVERAGE

*Monthly Benefit*

❑ 60% of salary to a maximum of $6,000

❑ I waive this coverage.

Guardian Group Plan Number: **382194**

Please print employee name:

## IMPORTANT NOTES

- Paying for disability income insurance pre-tax may cause the benefits to be taxable to the recipient at the time of payment.

## CHOOSE YOUR DENTAL COVERAGE

| | Option 1: PPO | Option 2: PPO | | |
|---|---|---|---|---|
| Employee alone | ❑ | ❑ | | ❑ I waive this coverage |
| Employee and Spouse | ❑ | ❑ | | ❑ 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 ❑ 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, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

## 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 knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

**SIGNATURE OF EMPLOYEE X** ______________________ **DATE** __________



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