Guardian

Group Insurance Enrollment/Change Form

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

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

Please print clearly and mark carefully.

Employer Name: HUMAN TECHNOLOGIES CORP.	Group Plan Number: 00507708	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Re-Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change ❑ Increase Amount ❑ Family Status Change

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

About You:

First, MI, Last Name:

Social Security Number ___-___-____

Address	City	State	Zip

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

Email Address:

Are you married or do you have a spouse? ❑ Yes ❑ No Date of marriage/union: ____-____-____

Do you have children or other dependents? ❑ Yes ❑ No Placement date of adopted child: ____-____-____

About Your Job:

Hours worked per week: _____ Job Title:

Work Status: ❑ Active ❑ Retired ❑ Cobra/State Continuation	Date of full time hire: ____-____-____	Annual Salary: $_____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender ❑ M ❑ F	Social Security Number ___-___-____ Date of Birth (mm-dd-yyyy) ____-____-____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ___-___-____ Date of Birth (mm-dd-yyyy) ____-____-____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ___-___-____ Date of Birth (mm-dd-yyyy) ____-____-____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Oct 16, 2020

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

Drop Coverage:

❑ Drop Employee ❑ Drop Dependents

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:

❑ Dental ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Vision ❑ Employee ❑ Spouse ❑ Child(ren)

❑ Specified Disease

❑ Short Term Disability

Loss Of Other Coverage:

I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to:

❑ Termination of Employment: _____-_____-_____

❑ Divorce _____-_____-_____

❑ Death of Spouse _____-_____-_____

❑ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ❑ Dental ❑ Vision

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)

Dental Coverage: You must be enrolled to cover your dependents. Check only one box.

	Employee Only	EE, Spouse & Dependent/Child(ren)
PPO	❑	❑

❑ I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:

- ❑ I am covered under another Dental plan
- ❑ My spouse is covered under another Dental plan
- ❑ My dependents are covered under another Dental plan

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

Your Bi-weekly Premium	Employee Only	EE, Spouse & Dependent/Child(ren)
Full Feature - Designer	❑ $3.48	❑ $7.48

❑ I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:

- ❑ I am covered under another Vision plan
- ❑ My spouse is covered under another Vision plan
- ❑ My dependents are covered under another Vision plan

Short-Term Disability (STD) Coverage:

Weekly Benefit

❑ 40% of salary to a maximum of $1,000

❑ I do not want this coverage.

Guardian Group Plan Number: 00507708 Please print employee name:

Specified Disease Coverage: You must be enrolled to cover your dependents

New York law requires that we ask you this question: Do you and your dependents have at least major medical insurance or at least basic hospital insurance and basic medical insurance in force on the date of this application for specified disease coverage? ❑ Yes. ❑ No If your answer to this question is "no", you and your dependents may not enroll for specified disease coverage.

Benefit reductions apply. Please see plan administrator.

Employee
Insurance Amount: ❑ $5,000 ❑ $10,000 ❑ $15,000 ❑ $20,000
❑ I do not want this coverage.

Spouse
Insurance Amount: Up to 50% of the employee's amount to a maximum of $10,000
❑ $2,500 ❑ $5,000 ❑ $7,500 ❑ $10,000
❑ I do not want this coverage.

Dependent/Child(ren)
Insurance Amount: ❑ 25% of the employee's amount
❑ I do not want this coverage.

Do you have on the date of this application, other specified disease coverage in force(or pending applications) for the same disease(s) for which you are applying for coverage herein for you and any dependents being enrolled? ❑ Yes. ❑ No.

Please indicate the number of specified diseases for which you have coverage in force(or pending applications)for yourself and any dependents being enrolled
Employee_____ Dependents:_____

IMPORTANT NOTES:

- Based on your plan benefits and age, you may be required to complete an additional evidence of insurability form for Specified Disease.
- I understand that I am enrolling in Specified Disease insurance. This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.
- No later than 30 days following delivery of specified disease coverage, Guardian will ask in a written request whether at least major medical insurance or at least basic hospital insurance and basic medical insurance (required underlying coverage) is in force on the effective date of the specified disease coverage. If Guardian receives a written response that the required underlying coverage is not in force for an insured person on the effective date of the specified disease coverage, the specified disease coverage for that insured person will be voided from its beginning with a full premium refund for such person.

Signature

- An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- 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.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- 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 agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

- I agree that my [employer] or my employer's designated administrator may deduct premiums from my pay apply premiums to my credit card or debit card add premiums to my dues withdraw premiums from my designated bank account, apply premiums to my credit or debit card if they are required for the coverage I have chosen.
- I state that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil Penalties, or denial of insurance benefits (Does not apply to Life Insurance).

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

READ YOUR CERTIFICATE CAREFULLY,CERTAIN WAR RISKS ARE NOT ASSUMED.IN CASE OF ANY DOUBT,CONTACT YOUR COMPANY FOR FURTHER EXPLANATION.

The following section applies to these coverage(s): Accident Coverage, Specified Disease Coverage, Hospital Indemnity Coverage:

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

If you have questions about the benefits provided by this coverage, please contact us at 1-888-541-7846.

I understand that I am enrolling in Accident Insurance, Hospital Indemnity Insurance, and/or Specified Disease Insurance. Accident Insurance does not provide coverage for sickness. These coverages are a supplement to health insurance and are not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes. Also, under New York law, I must have at least major medical insurance or at least basic hospital insurance and basic medical insurance on the date of this application to enroll for Accident Insurance, Hospital Indemnity Insurance, and/or Specified Disease Insurance.

By my signature below, I affirmatively consent to receive electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I understand that I may change my election by providing Guardian 30 days prior written notice. I am opting out of receiving electronic copies of applicable insurance related documents and I understand such documents will be mailed to me at the address provided.

SIGNATURE OF EMPLOYEE X _____ DATE _____

Enrollment Kit 00507708, 0001, EN

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.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

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.