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

Please print clearly and mark carefully.

Employer Name: City of Davenport	Group Plan Number: 00579940	Benefits Effective:_____

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

Class: All Employees Eligible for Voluntary Life 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 (indicate primary): ❑ Home (____) ____ - ____
❑ Work (____) ____ - ____
❑ Mobile (____) ____ - ____

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

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: Job Title:

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

About Your Family: Please include the names of the dependents you wish to enroll for coverage. 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-yy) 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 (First, MI, Last Name)		Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 2:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 3:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 4:	❑ Add ❑ Drop	Gender ❑ M ❑ F	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: Nov 16, 2020

LIFE INSURANCE *continued*

Voluntary Term Life Coverage: You must be enrolled to cover your dependents. *Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

Employee

Policy Amount *Check one box only*

❑ $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	❑ $220,000	❑ $230,000	❑ $240,000
❑ $250,000	❑ $260,000	❑ $270,000	❑ $280,000	❑ $290,000	❑ $300,000

*Guarantee Issue Amount. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

❑ I do not want this coverage

Add Voluntary Life for Spouse

Policy Amount

❑ $5,000	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000
❑ $35,000	❑ $40,000	❑ $45,000	❑ $50,000*		

**Guarantee Issue Amount*

**The amount may not be more than 100% of the employee amount for Voluntary Life.*

❑ I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

❑ $2,500 ❑ $5,000*

**Guarantee Issue Amount*

**The amount may not be more than 50% of the employee amount for Voluntary Life.*

❑ I do not want this coverage

Voluntary Accidental Death and Dismemberment (AD&D) Coverage: Check one box only You must be enrolled to cover your dependents.

Employee Only

The amount of AD&D coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of cove rage covering you or your dependents.

Policy Amount

❑ $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		

❑ I do not want this coverage

Spouse

Policy Amount *Check one box only*

❑ $5,000	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000
❑ $35,000	❑ $40,000	❑ $45,000	❑ $50,000		

** The amount may not be more than 100% of the employee amount for Voluntary Accidental Death & Dismemberment.*

❑ I do not want this coverage

Child(ren)

Policy Amount *Check one box only*

❑ $2,500 ❑ $5,000

**The amount may not be more than 50% of the employee amount for Voluntary Accidental Death & Dismemberment.*

❑ I do not want this coverage

LIFE INSURANCE *continued*

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

Name your beneficiaries: (Primary beneficiary percentages must total 100%)
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:_____

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

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

Phone: ( ) - Relationship to Employee:_____

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

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

Phone: ( ) - Relationship to Employee:_____

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

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

Please contact your employer for any record of or changes to your beneficiary information.

Spouse and dependent child(ren) – If the intended beneficiary is to be someone other than the employee, 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 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 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.
- I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

- 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.
- I consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice.
- I attest 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 statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

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 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.

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.

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.

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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

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 or 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 or denial of insurance benefits.

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.

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style.

Policy Election Amount	Bi-weekly premiums displayed. Policy Election Cost Per Age Bracket								
Employee	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$10,000	$.31	$.41	$.46	$.65	$1.00	$1.61	$2.47	$3.75	$6.45
$20,000	$.62	$.81	$.91	$1.29	$1.99	$3.22	$4.94	$7.50	$12.90
$30,000	$.93	$1.22	$1.37	$1.94	$2.99	$4.83	$7.41	$11.24	$19.34
$40,000	$1.24	$1.63	$1.83	$2.59	$3.99	$6.44	$9.88	$14.99	$25.79
$50,000	$1.55	$2.03	$2.29	$3.23	$4.99	$8.05	$12.35	$18.74	$32.24
$60,000	$1.86	$2.44	$2.74	$3.88	$5.98	$9.67	$14.82	$22.49	$38.69
$70,000	$2.17	$2.84	$3.20	$4.52	$6.98	$11.28	$17.29	$26.23	$45.13
$80,000	$2.47	$3.25	$3.66	$5.17	$7.98	$12.89	$19.75	$29.98	$51.58
$90,000	$2.78	$3.66	$4.11	$5.82	$8.97	$14.50	$22.22	$33.73	$58.03
$100,000	$3.09	$4.06	$4.57	$6.46	$9.97	$16.11	$24.69	$37.48	$64.48
$110,000	$3.40	$4.47	$5.03	$7.11	$10.97	$17.72	$27.16	$41.23	$70.93
$120,000	$3.71	$4.87	$5.48	$7.75	$11.96	$19.33	$29.63	$44.97	$77.37
$130,000	$4.02	$5.28	$5.94	$8.40	$12.96	$20.94	$32.10	$48.72	$83.82
$140,000	$4.33	$5.69	$6.40	$9.05	$13.96	$22.55	$34.57	$52.47	$90.27
$150,000	$4.64	$6.09	$6.85	$9.69	$14.95	$24.16	$37.04	$56.22	$96.72
$160,000	$4.95	$6.50	$7.31	$10.34	$15.95	$25.77	$39.51	$59.96	$103.16
$170,000	$5.26	$6.91	$7.77	$10.99	$16.95	$27.38	$41.98	$63.71	$109.61
$180,000	$5.57	$7.31	$8.23	$11.63	$17.95	$28.99	$44.45	$67.46	$116.06
$190,000	$5.88	$7.72	$8.68	$12.28	$18.94	$30.61	$46.92	$71.21	$122.51
$200,000	$6.19	$8.12	$9.14	$12.92	$19.94	$32.22	$49.39	$74.95	$128.95
$210,000	$6.49	$8.53	$9.60	$13.57	$20.94	$33.83	$51.85	$78.70	$135.40
$220,000	$6.80	$8.94	$10.05	$14.22	$21.93	$35.44	$54.32	$82.45	$141.85
$230,000	$7.11	$9.34	$10.51	$14.86	$22.93	$37.05	$56.79	$86.20	$148.30
$240,000	$7.42	$9.75	$10.97	$15.51	$23.93	$38.66	$59.26	$89.95	$154.75
$250,000	$7.73	$10.15	$11.42	$16.15	$24.92	$40.27	$61.73	$93.69	$161.19
$260,000	$8.04	$10.56	$11.88	$16.80	$25.92	$41.88	$64.20	$97.44	$167.64
$270,000	$8.35	$10.97	$12.34	$17.45	$26.92	$43.49	$66.67	$101.19	$174.09
$280,000	$8.66	$11.37	$12.79	$18.09	$27.91	$45.10	$69.14	$104.94	$180.54
$290,000	$8.97	$11.78	$13.25	$18.74	$28.91	$46.71	$71.61	$108.68	$186.98

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$300,000	$9.28	$12.19	$13.71	$19.39	$29.91	$48.32	$74.08	$112.43	$193.43
Policy Election Amount									
Spouse									
$5,000	$.16	$.20	$.23	$.32	$.50	$.81	$1.24	$1.87	$3.22
$10,000	$.31	$.41	$.46	$.65	$1.00	$1.61	$2.47	$3.75	$6.45
$15,000	$.46	$.61	$.69	$.97	$1.50	$2.42	$3.70	$5.62	$9.67
$20,000	$.62	$.81	$.91	$1.29	$1.99	$3.22	$4.94	$7.50	$12.90
$25,000	$.77	$1.02	$1.14	$1.62	$2.49	$4.03	$6.17	$9.37	$16.12
$30,000	$.93	$1.22	$1.37	$1.94	$2.99	$4.83	$7.41	$11.24	$19.34
$35,000	$1.08	$1.42	$1.60	$2.26	$3.49	$5.64	$8.64	$13.12	$22.57
$40,000	$1.24	$1.63	$1.83	$2.59	$3.99	$6.44	$9.88	$14.99	$25.79
$45,000	$1.39	$1.83	$2.06	$2.91	$4.49	$7.25	$11.11	$16.87	$29.02
$50,000	$1.55	$2.03	$2.29	$3.23	$4.99	$8.05	$12.35	$18.74	$32.24
Policy Election Amount									
Child(ren)									
$2,500	$0.11	$0.11	$0.11	$0.11	$0.11	$0.11	$0.11	$0.11	$0.11
$5,000	$0.23	$0.23	$0.23	$0.23	$0.23	$0.23	$0.23	$0.23	$0.23

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.

Premiums for Voluntary Life Increase in five-year increments

Infant coverage is limited for the first two weeks of infant's life.

Spouse coverage premium is based on Employee age.

†Benefit reductions apply.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. 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 one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-1-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

Accidental Death and Dismemberment Life Cost Illustration:

AD&D coverage provides additional benefits following an accidental death or certain bodily injuries.

Employee Policy Election Amount	Bi-weekly Premiums displayed	Spouse Policy Election Amount	Bi-weekly Premiums displayed	Child(ren) Policy Election Amount	Bi-weekly Premiums displayed
$10,000	$0.13	$5,000	$0.07	$2,500	$0.03
$20,000	$0.27	$10,000	$0.13	$5,000	$0.07
$30,000	$0.40	$15,000	$0.20		
$40,000	$0.54	$20,000	$0.27		
$50,000	$0.67	$25,000	$0.34		
$60,000	$0.80	$30,000	$0.40		
$70,000	$0.94	$35,000	$0.47		
$80,000	$1.07	$40,000	$0.54		
$90,000	$1.21	$45,000	$0.60		
$100,000	$1.34	$50,000	$0.67		
$110,000	$1.47				
$120,000	$1.61				
$130,000	$1.74				
$140,000	$1.87				
$150,000	$2.01				
$160,000	$2.14				
$170,000	$2.28				
$180,000	$2.41				
$190,000	$2.54				
$200,000	$2.68				
$210,000	$2.81				
$300,000	$4.02				

Infant coverage is limited for the first two weeks of infant's life.
Benefit reductions apply.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATION AND EXCLUSIONS FOR AD&D

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. 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 one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. This proposal is hedged subject to satisfactory financial evaluation. Please refer to policy booklet for full plan description.
Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.
We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al.
We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated.
The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.
Enhanced AD&D: A loss may be defined as death, quadriplegia, loss of speech and hearing, loss of cognitive function, comatose state in excess of one month, hemiplegia or paraplegia. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.