The Guardian Life Insurance company of America (referred to in the form as "Guardian") underwrites group term life, accidental death and dismemberment, short term disability, long term disability, dental, vision, critical illness, cancer and hospital indemnity coverages.

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

Please print clearly and mark carefully.

Employer Name: **Kansas City Orthopaedic Institute**	Group Plan Number: **00041266**	Benefits Effective:_____

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

Class: All Eligible KCOI Employees Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:

First, MI, Last Name:

Employer 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: ❑ 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 partner? ❑ Yes ❑ No
Do you have children or other dependents? ❑ Yes ❑ No

Date of marriage/union:____-____-_____
If a child is adopted, date of legal adoption:
____-____-_____

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. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency 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.**

Spouse or Partner		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: Sep 22, 2022

Basic Life Coverage:

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.

Policy Amount

Employee Only

☑ 100% of your annual salary to a maximum of $50,000

The Guarantee Issue Amount is $50,000.

* If Employee is 65+ benefit reductions may apply which may change the GI amount. Please see enrollment materials for details.

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

If additional space is needed, please attach a separate sheet of paper with this infformation along with your enrollment form. Be sure to sign and date (mm-dd-yy) 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.)

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

Spouse or Partner 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: ( ) -

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

Important Notes:

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

LIFE INSURANCE *continued*

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D): **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
❑ $310,000	❑ $320,000	❑ $330,000	❑ $340,000	❑ $350,000	❑ $360,000
❑ $370,000	❑ $380,000	❑ $390,000	❑ $400,000	❑ $410,000	❑ $420,000
❑ $430,000	❑ $440,000	❑ $450,000	❑ $460,000	❑ $470,000	❑ $480,000
❑ $490,000	❑ $500,000				

Guarantee Issue up to: Employee Less than age 65 $150,000*, 65-69 $50,000, 70+ $10,000. 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 or Partner**

Policy Amount

❑ $5,000	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ **$30,000***
❑ $35,000	❑ $40,000	❑ $45,000	❑ $50,000	❑ $55,000	❑ $60,000
❑ $65,000	❑ $70,000	❑ $75,000	❑ $80,000	❑ $85,000	❑ $90,000
❑ $95,000	❑ $100,000	❑ $105,000	❑ $110,000	❑ $115,000	❑ $120,000
❑ $125,000	❑ $130,000	❑ $135,000	❑ $140,000	❑ $145,000	❑ $150,000
❑ $155,000	❑ $160,000	❑ $165,000	❑ $170,000	❑ $175,000	❑ $180,000
❑ $185,000	❑ $190,000	❑ $195,000	❑ $200,000	❑ $205,000	❑ $210,000
❑ $215,000	❑ $220,000	❑ $225,000	❑ $230,000	❑ $235,000	❑ $240,000
❑ $245,000	❑ $250,000				

Guarantee Issue up to: Spouse Less than age 65 $30,000*, 65-69 $10,000, 70+ $0.

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

❑ I do not want this coverage

Add **Voluntary Life for Dependent/Child(ren)**

Policy Amount

❑ $2,000	❑ $4,000	❑ $6,000	❑ $8,000	❑ **$10,000***

**Guarantee Issue Amount*

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

❑ I do not want this coverage

Important Notes:

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic 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:**_____

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 or Partner 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.

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: ( ) -

Long-Term Disability (LTD) Coverage:

The amount of LTD 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.

Monthly Benefit
☑ 66.67% of salary to a maximum of $10,000

Signature

- I understand that my dependent(s) 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, 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.
- 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 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.
- 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.
- By my signature below, I affirmatively 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
- By my signature below, I affirmatively consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- **I attest that the information provided above is true and correct to the best of my knowledge.**
- **The English version of the contract of insurance or indemnity is the official or controlling version and the version written in any language other than English is furnished for informational purposes only. (La version en inglés del contrato de seguro o de cobertura es la version oficial o dominante y la version redactada en cualquier otro idioma distinto del inglés se proporciona con fines informativos únicamente.)**

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 hereto, may be guilty of committing a fraudulent insurance act as determined by a court of law, which may be 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.

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: 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.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

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.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly 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 subject to the conditions/provisions of the policy.

Oregon: 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, may be committing a fraudulent act, and may be subject to civil penalties or dental of insurance benefits.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

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.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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.