Basic and Supplemental (Optional) Life Insurance- Active Employee Only

Guardian **Customer Service** **1-888-600-1600**
www.guardianlife.com

Basic Life: You may elect $2,000 of Basic Term life insurance coverage. The Basic Life includes Enhanced Accidental Death and Dismemberment coverage equal to one times the employee's life benefit.
Optional Term Life: You may elect $25,000, $50,000, $100,000, $150,000, or $200,000. All election amounts during open enrollment are subject to Evidence of Insurability.
Spouse Term Life: You may elect 50% of the employee optional coverage up to $25,000.
Dependent Term Life: Coverage of $10,000 for each dependent. Covers children age 14 days to 23 years (25 years if a full time student).

NOTE: Life Rates will change October 1, 2013

	Monthly Deduction	22 Week Deduction	39 Week Deduction	Retiree Deduction
Basic Life Insurance	**$1.63**	**$1.96**	**$2.17**	**$2.80**
Dependent Child Life	**$1.70**	**$2.04**	**$2.27**	**$1.70**

Optional Life Insurance Rates for Employees & Retirees

Age	Monthly Deduction	22 Week Deduction	39 Week Deduction
Less than 30	$.10	$.12	$.13
30-34	$.11	$.13	$.15
35-39	$.14	$.17	$.19
40-44	$.21	$.26	$.28
45-49	$.35	$.42	$.47
50-54	$.52	$.62	$.69
55-59	$.78	$..94	$1.04
60-64	$1.28	$1.54	$1.71
65-69	$2.48	$2.98	$3.31
70-75	$3.28	$3.94	$4.37

Premium deductions are taken on the first of every month.
The optional term life ends at age 75. The spouse life terms when the employee turns age 70.

Spouse Life Insurance Rates

Rate/1000

Age	Monthly Deduction	22 Week Deduction	39 Week Deduction
Less than 30	$.10	$.12	$.13
30-34	$.11	$.13	$.15
35-39	$.14	$.17	$.19
40-44	$.21	$.26	$.28
45-49	$.35	$.42	$.47
50-54	$.52	$.62	$.69
55-59	$.78	$..94	$1.04
60-64	$1.28	$1.54	$1.71
65-69	$2.48	$2.98	$3.31

Life Insurance for the spouse terminates at age 70.
(based on employee's age)

How do I determine what the optional life insurance cost will be?

Select the correct rate for your age and pay schedule and multiply by the volume of life insurance divided by 1000. For $50,000 of life insurance you would use 50 as the volume.

Example: I am 42 year old employee and I wish to elect $50,000 of life insurance and I receive 22 paychecks a year.

The age 42 rate is $.26/ 1000

$.26 X 50k = $13 per Month

Any questions, please call the Insurance Department at 787-6055 of contact the Guardian Hotline at 1-888-600-1600.

Please print clearly to ensure accurate processing

GUARDIAN®

Employer:
City of Springfield
36 Court Street
Springfield, MA 01103

Guardian Group Plan Number: **459295**

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 Active Employees			/ /

Keep a copy for your records and return form to: **Northeast Regional Office, P.O. Box 26040, Lehigh Valley, PA 18002-6040**

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 (mm/dd/yyyy)	
		/ /	- -	/ /	
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

CHOOSE YOUR BASIC LIFE COVERAGE

	Policy Amount
Employee	☐ $2,000

☐ I waive this coverage

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Nov 01, 2011

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.

❑ $25,000 ❑ $50,000 ❑ **$100,000*** ❑ $150,000 ❑ **$200,000****

**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 $25,000

❑ 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*

❑ **$10,000***

**Guarantee Issue Amount*

❑ 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 received medical care, including treatment, consultation, services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer; Heart Disease; Diabetes; any condition related to AIDS or AIDS Related Complex; or any other Chronic 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.

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 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 be guilty of insurance fraud.**

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER