Guardian

HIGHLAND COUNTY
ALL OTHER ELIGIBLE EMPLOYEES
Group Number: 00564909

Customer Service (888) 600-1600
Monday to Friday | 8am to 8:30pm ET

Welcome to
Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Your coverage options

Vision insurance	Looking after your eyesight and related health issues
Life insurance	Protecting your family's financial future

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1. Read through this information.
2. Find out more about your benefits.
3. Talk to your employer if you need help or have any questions.

This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

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Watch our video
How vision insurance can help you see clearly as you get older.*

Vision insurance

Vision insurance helps protect the health of your eyes by providing coverage for benefits that often aren't covered by regular medical insurance.

Protecting your eyesight means allowing for routine visits to the optometrist for eye exams, as well as coverage for glasses and contacts. Make sure your eyes remain in great shape at any age – no matter how much time you spend staring at digital screens.

Who is it for?

Even if you have perfect eyesight, it's important to have regular eye exams to make sure you're still seeing clearly. Most of us may eventually need vision correction, which is why we offer vision insurance to cover some of the costs.

What does it cover?

Vision insurance covers benefits not typically included in medical insurance plans. It covers things like routine eye exams, allowances towards the purchase of eyeglasses and contact lenses, as well as discounts on corrective Lasik surgery.

Why should I consider it?

Regular eye exams can detect more than failing eyesight, they can also pick up diseases like glaucoma and diabetes. Vision problems are one of the most prevalent disabilities in the United States, making vision insurance especially useful for anyone who regularly needs to purchase eyeglasses or contacts, or anyone who simply wants to help protect their eyesight and general health.

20/20 coverage

David notices that his vision is deteriorating. He goes in for an eye exam, and is diagnosed with myopia, which means he needs glasses.

David feels eye strain, and notices that he can't see certain things as clearly as he once did. He goes in for an eye exam and is diagnosed with myopia (nearsightedness), which means he needs glasses.

His vision plan helps him find a quality eye doctor and pays for the exam, and makes it possible for him to buy new glasses at a discount.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

You will receive these benefits if you meet the conditions listed in the policy. *Guardian will never ask you to provide sensitive personal information, including SSN/DOB, nor login via QR codes.

Guardian®

Your vision coverage

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of VSP's network locations.

Your Vision Plan	**Full Feature**	
Your Network is	VSP Choice Network	
Your Bi-weekly premium	**$ 1.30**	
You, Spouse and Child(ren)	$ 3.58	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 20	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $39
Single Vision Lenses	$0	Amount over $23
Lined Bifocal Lenses	$0	Amount over $37
Lined Trifocal Lenses	$0	Amount over $49
Lenticular Lenses	$0	Amount over $64
Frames	80% of amount over $130[1]	Amount over $46
Contact Lenses *(Elective)*	Amount over $130	Amount over $100
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price**	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every two calendar years‡‡‡	
Network discounts *(glasses and contact lens professional service)*	Limitless within 12 months of exam.	
Dependent Age Limits	26	
	Visit www.Guardianlife.com and click on "Find a Provider"	

VSP

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.
- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.
- [1]Extra $20 on select brands
- Members can use their in network benefits on line at Eyeconic.com.

Your vision coverage

- ‡‡‡.*The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.*
- In Network Routine Retinal Screening Covered after no more than a $39 copay.

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-VSN-96-VIS et al.

Laser Correction Surgery:

Discounts on average of 10-20% off usual and customary charge or 5% off promotional price for vision laser Surgery. Members out-of-pocket costs are limited to $1,800 per eye for LASIK or $1,500 per eye for PRK or $2300 per eye for Custom LASIK, Custom PRK, or Bladeless LASIK.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

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Guardian®

Watch our video
How life insurance protects families and covers critical costs.*

Life insurance

If something happens to you, life insurance can help provide your family with financial security.

Life insurance helps protect you family's finances by providing a death benefit if you pass away.** This helps ensure that they'll be financially supported, and can cover important things from bills to funeral costs. With life policies, you can get cost-effective life insurance protection for a set period of time.

Who is it for?

Everyone's life insurance needs are different, depending on their family situation. That's why group life insurance through an employer can be a more cost-effective option than individual life insurance.

What does it cover?

Life insurance protects your loved ones by providing a benefit (which is usually tax-exempt) if you pass away.

Why should I consider it?

Life insurance is about more than just covering expenses. Depending on your circumstances, it could take your family years to recover from the loss of your income.

With a life insurance benefit, your family will have extra money to cover mortgage and rent payments, legal or medical fees, childcare, tuition, and any outstanding debts.

You will receive these benefits if you meet the conditions listed in the policy. Guardian, its subsidiaries, agents, and employees do not provide tax, legal, or accounting advice. Consult your tax, legal, or accounting professional regarding your individual situation. *Guardian will never ask you to provide sensitive personal information, including SSN/DOB, nor login via QR. **As long as premiums are paid.

Preparing and planning

Jorge's never considered purchasing life insurance, but after being offered it through work, he decides it's a good way to protect his family.

Jorge has a mortgage. His wife helps take care of her mother and only works part-time. With his daughter about to start college, he knows that many expenses would go unmet if his family lost him.

Jorge purchases enough life insurance coverage to help cover the mortgage, tuition, and family living costs if something happens to him.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Guardian®

Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides $15,000 Basic Term Life coverage for all full time employees.	$10,000 increments to a maximum of $250,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage.	Employee, Spouse & Child(ren) coverage. Maximum 1 times life amount.
Spouse Benefit	N/A	$5,000 increments to a maximum of $250,000. See Cost Illustration page for details.‡
Child Benefit	N/A	Your dependent children age 14 days to 26 years. $1,000 increments to a maximum of $10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	Guarantee Issue coverage up to $15,000 per employee	We Guarantee Issue coverage up to: Employee Less than age 65 $150,000, 65-69 $50,000, 70+ $10,000. Spouse Less than age 65 $25,000, 65-69 $10,000, 70+ $0. Dependent children $10,000.
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions	Yes, with age and other restrictions

Guardian®

Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	No	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits

‡ **Spouse coverage terminates at age 70.**

The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

Annual Election Option allows employees to increase the amount of their life coverage without a medical exam when they re-enroll in their company's Voluntary Life plan. This option allows employees to step up to an amount of up to $50,000, up to the Guarantee Issue amount.

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.

Bi-weekly premiums displayed. Cost of AD&D is included.

Policy Election Amount	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	$.64	$.67	$.86	$1.21	$1.87	$3.01	$4.80	$7.75	$16.18
$20,000	$1.28	$1.34	$1.73	$2.43	$3.73	$6.01	$9.60	$15.49	$32.35
$30,000	$1.93	$2.01	$2.59	$3.64	$5.59	$9.01	$14.40	$23.23	$48.53
$40,000	$2.57	$2.68	$3.45	$4.86	$7.46	$12.02	$19.20	$30.98	$64.71
$50,000	$3.21	$3.35	$4.32	$6.07	$9.32	$15.02	$24.00	$38.72	$80.89
$60,000	$3.85	$4.02	$5.18	$7.28	$11.19	$18.03	$28.80	$46.47	$97.06
$70,000	$4.49	$4.69	$6.04	$8.50	$13.05	$21.03	$33.60	$54.21	$113.24
$80,000	$5.13	$5.35	$6.91	$9.71	$14.92	$24.04	$38.40	$61.96	$129.42
$90,000	$5.77	$6.02	$7.77	$10.93	$16.78	$27.04	$43.20	$69.70	$145.59
$100,000	$6.42	$6.69	$8.63	$12.14	$18.65	$30.05	$48.00	$77.45	$161.77
$110,000	$7.06	$7.36	$9.49	$13.35	$20.51	$33.05	$52.80	$85.19	$177.95
$120,000	$7.70	$8.03	$10.36	$14.57	$22.38	$36.06	$57.60	$92.94	$194.12
$130,000	$8.34	$8.70	$11.22	$15.78	$24.24	$39.06	$62.40	$100.68	$210.30
$140,000	$8.98	$9.37	$12.08	$16.99	$26.11	$42.07	$67.20	$108.43	$226.48
$150,000	$9.62	$10.04	$12.95	$18.21	$27.97	$45.07	$72.00	$116.17	$242.65
$160,000	$10.27	$10.71	$13.81	$19.42	$29.83	$48.07	$76.80	$123.91	$258.83
$170,000	$10.91	$11.38	$14.67	$20.64	$31.70	$51.08	$81.60	$131.66	$275.01
$180,000	$11.55	$12.05	$15.54	$21.85	$33.56	$54.08	$86.40	$139.40	$291.19
$190,000	$12.19	$12.72	$16.40	$23.06	$35.43	$57.09	$91.20	$147.15	$307.36
$200,000	$12.83	$13.39	$17.26	$24.28	$37.29	$60.09	$96.00	$154.89	$323.54
$210,000	$13.47	$14.05	$18.13	$25.49	$39.16	$63.10	$100.80	$162.64	$339.72
$220,000	$14.11	$14.72	$18.99	$26.71	$41.02	$66.10	$105.60	$170.38	$355.89
$230,000	$14.76	$15.39	$19.85	$27.92	$42.89	$69.11	$110.40	$178.13	$372.07
$240,000	$15.40	$16.06	$20.71	$29.13	$44.75	$72.11	$115.20	$185.87	$388.25
$250,000	$16.04	$16.73	$21.58	$30.35	$46.62	$75.12	$120.00	$193.62	$404.42
Policy Election Amount									
Spouse									
$10,000	$.64	$.67	$.86	$1.21	$1.87	$3.01	$4.80	$7.75	$16.18
$15,000	$.96	$1.00	$1.30	$1.82	$2.80	$4.51	$7.20	$11.62	$24.27

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$20,000	$1.28	$1.34	$1.73	$2.43	$3.73	$6.01	$9.60	$15.49	$32.35
$25,000	$1.60	$1.67	$2.16	$3.04	$4.66	$7.51	$12.00	$19.36	$40.44
$30,000	$1.93	$2.01	$2.59	$3.64	$5.59	$9.01	$14.40	$23.23	$48.53
$35,000	$2.25	$2.34	$3.02	$4.25	$6.53	$10.52	$16.80	$27.11	$56.62
$40,000	$2.57	$2.68	$3.45	$4.86	$7.46	$12.02	$19.20	$30.98	$64.71
$45,000	$2.89	$3.01	$3.88	$5.46	$8.39	$13.52	$21.60	$34.85	$72.80
$50,000	$3.21	$3.35	$4.32	$6.07	$9.32	$15.02	$24.00	$38.72	$80.89
$55,000	$3.53	$3.68	$4.75	$6.68	$10.26	$16.53	$26.40	$42.60	$88.97
$60,000	$3.85	$4.02	$5.18	$7.28	$11.19	$18.03	$28.80	$46.47	$97.06
$65,000	$4.17	$4.35	$5.61	$7.89	$12.12	$19.53	$31.20	$50.34	$105.15
$70,000	$4.49	$4.69	$6.04	$8.50	$13.05	$21.03	$33.60	$54.21	$113.24
$75,000	$4.81	$5.02	$6.47	$9.10	$13.99	$22.54	$36.00	$58.09	$121.33
$80,000	$5.13	$5.35	$6.91	$9.71	$14.92	$24.04	$38.40	$61.96	$129.42
$85,000	$5.45	$5.69	$7.34	$10.32	$15.85	$25.54	$40.80	$65.83	$137.50
$90,000	$5.77	$6.02	$7.77	$10.93	$16.78	$27.04	$43.20	$69.70	$145.59
$95,000	$6.10	$6.36	$8.20	$11.53	$17.71	$28.54	$45.60	$73.57	$153.68
$100,000	$6.42	$6.69	$8.63	$12.14	$18.65	$30.05	$48.00	$77.45	$161.77
$105,000	$6.74	$7.03	$9.06	$12.75	$19.58	$31.55	$50.40	$81.32	$169.86
$110,000	$7.06	$7.36	$9.49	$13.35	$20.51	$33.05	$52.80	$85.19	$177.95
$115,000	$7.38	$7.70	$9.93	$13.96	$21.44	$34.55	$55.20	$89.06	$186.04
$120,000	$7.70	$8.03	$10.36	$14.57	$22.38	$36.06	$57.60	$92.94	$194.12
$125,000	$8.02	$8.37	$10.79	$15.17	$23.31	$37.56	$60.00	$96.81	$202.21
$130,000	$8.34	$8.70	$11.22	$15.78	$24.24	$39.06	$62.40	$100.68	$210.30
$135,000	$8.66	$9.04	$11.65	$16.39	$25.17	$40.56	$64.80	$104.55	$218.39
$140,000	$8.98	$9.37	$12.08	$16.99	$26.11	$42.07	$67.20	$108.43	$226.48
$145,000	$9.30	$9.70	$12.52	$17.60	$27.04	$43.57	$69.60	$112.30	$234.57
$150,000	$9.62	$10.04	$12.95	$18.21	$27.97	$45.07	$72.00	$116.17	$242.65
$155,000	$9.94	$10.37	$13.38	$18.82	$28.90	$46.57	$74.40	$120.04	$250.74
$160,000	$10.27	$10.71	$13.81	$19.42	$29.83	$48.07	$76.80	$123.91	$258.83
$165,000	$10.59	$11.04	$14.24	$20.03	$30.77	$49.58	$79.20	$127.79	$266.92
$170,000	$10.91	$11.38	$14.67	$20.64	$31.70	$51.08	$81.60	$131.66	$275.01
$175,000	$11.23	$11.71	$15.10	$21.24	$32.63	$52.58	$84.00	$135.53	$283.10

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$180,000	$11.55	$12.05	$15.54	$21.85	$33.56	$54.08	$86.40	$139.40	$291.19
$185,000	$11.87	$12.38	$15.97	$22.46	$34.50	$55.59	$88.80	$143.28	$299.27
$190,000	$12.19	$12.72	$16.40	$23.06	$35.43	$57.09	$91.20	$147.15	$307.36
$195,000	$12.51	$13.05	$16.83	$23.67	$36.36	$58.59	$93.60	$151.02	$315.45
$200,000	$12.83	$13.39	$17.26	$24.28	$37.29	$60.09	$96.00	$154.89	$323.54
$205,000	$13.15	$13.72	$17.69	$24.88	$38.23	$61.60	$98.40	$158.77	$331.63
$210,000	$13.47	$14.05	$18.13	$25.49	$39.16	$63.10	$100.80	$162.64	$339.72
$215,000	$13.79	$14.39	$18.56	$26.10	$40.09	$64.60	$103.20	$166.51	$347.80
$220,000	$14.11	$14.72	$18.99	$26.71	$41.02	$66.10	$105.60	$170.38	$355.89
$225,000	$14.44	$15.06	$19.42	$27.31	$41.95	$67.60	$108.00	$174.25	$363.98
$230,000	$14.76	$15.39	$19.85	$27.92	$42.89	$69.11	$110.40	$178.13	$372.07
$235,000	$15.08	$15.73	$20.28	$28.53	$43.82	$70.61	$112.80	$182.00	$380.16
$240,000	$15.40	$16.06	$20.71	$29.13	$44.75	$72.11	$115.20	$185.87	$388.25
$245,000	$15.72	$16.40	$21.15	$29.74	$45.68	$73.61	$117.60	$189.74	$396.34
$250,000	$16.04	$16.73	$21.58	$30.35	$46.62	$75.12	$120.00	$193.62	$404.42
Policy Election Amount									
Child(ren)									
$1,000	$0.09	$0.09	$0.09	$0.09	$0.09	$0.09	$0.09	$0.09	$0.09
$2,000	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19	$0.19
$3,000	$0.28	$0.28	$0.28	$0.28	$0.28	$0.28	$0.28	$0.28	$0.28
$4,000	$0.37	$0.37	$0.37	$0.37	$0.37	$0.37	$0.37	$0.37	$0.37
$5,000	$0.46	$0.46	$0.46	$0.46	$0.46	$0.46	$0.46	$0.46	$0.46
$6,000	$0.56	$0.56	$0.56	$0.56	$0.56	$0.56	$0.56	$0.56	$0.56
$7,000	$0.65	$0.65	$0.65	$0.65	$0.65	$0.65	$0.65	$0.65	$0.65
$8,000	$0.74	$0.74	$0.74	$0.74	$0.74	$0.74	$0.74	$0.74	$0.74
$9,000	$0.84	$0.84	$0.84	$0.84	$0.84	$0.84	$0.84	$0.84	$0.84
$10,000	$0.93	$0.93	$0.93	$0.93	$0.93	$0.93	$0.93	$0.93	$0.93

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

Premiums for Voluntary Life Increase in five-year increments

Spouse coverage premium is based on Employee age.

†Benefit reductions apply.

The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE AND AD&D 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.

Voluntary Life Only:

We pay no benefits if the insured employee or spouse death is due to suicide within two years from the insured employee or spouse 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-LB-90, 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.

For AD&D: 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.

*the willful self-injury does not apply to children with Voluntary AD&D

Guardian®

Electronic Evidence of Insurability (EOI)

Completing your Evidence of Insurability (EOI) online — it's simple, secure, and takes just a few minutes.

There are a few situations where you need to answer health questions, enroll for higher amounts of coverage, or request coverage after the initial eligibility period. In all of these situations, our online EOI form keeps things simple.

Electronic EOI keeps things simple

With Guardian's electronic EOI forms, your data is kept secure at every stage of the process. And with fewer errors than hand-written forms, and faster submission digitally, it's easier than ever to complete it and get covered.

Electronic EOI can be used for:*

- Basic life
- Voluntary life
- Short-term disability
- Long-term disability

How it works

You will receive a letter or email from your employer or Guardian with instructions and a unique link to submit your EOI form online.

First register and create an account on Guardian Anytime. Then simply fill out the form, electronically sign it, and click 'Submit.'

Once we receive the form, we'll contact you with any questions, before notifying you (and your employer if the coverage amount changes).

*Applicable to coverage requiring full evidence of insurability (not applicable to conditional issue amounts).

8197977.1 (07/27)

Guardian®

GuidanceResources® your Employee Assistance Program

Sometimes life can feel overwhelming. It doesn't have to.

Guardian's Employee Assistance Program provides confidential counseling, specialized guidance, and valuable resources to help you handle any of life's challenges, big or small.

How it can help

Confidential emotional support

- Anxiety, depression, and stress

Work and lifestyle support

- Child, elder, and pet care

Financial resources and legal guidance

- Retirement planning and taxes
- Wills, trusts, and estate planning

How to access
24/7 live assistance

Call
1 855 239 0743
TRS: Dial 711

Visit
guidanceresources.com

App: GuidanceNow℠
Organization web ID: Guardian
Note: First-time users will need to register first with the organization web ID: Guardian.

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

ComPsych Corporation (ComPsych) is a vendor to The Guardian Life Insurance Company of America (Guardian). ComPsych and Guardian are not affiliated entities. The Employee Assistance Program (Services) is provided by ComPsych. Guardian does not control or provide any part of the Services and does not bear any liability for their provision. This informational resource is not a contract and is for illustrative purposes only. Only the policy contains applicable terms. Guardian and ComPsych reserve the right to discontinue Services at anytime without notice. Services may not be available in all states. Legal/financial assistance and resources services are not available in the states of New York and Hawaii.

8197720.1 (07/27)

Guardian

EstateGuidance®
Online Will Preparation

Secure your wishes with a legally binding will.

EstateGuidance makes drafting a will easy with online tools that walk you through the process in minutes. You can also draft a living will to ensure you get the end-of-life care you desire and a final arrangements document expressing your wishes for your funeral services.

How it can help

Complete a customized will:
No cost to you

Have your will printed and sent to you:
$14.99

Draft a living will:
$14.99

Draft a final arragements document:
$9.99

How to access
24/7 live assistance

Call
1 855 239 0743
TRS: Dial 711

Visit
estateguidance.com

App: GuidanceNow℠
Enter promotional code:
Guardian

This service is only available if you purchase qualifying lines of coverage.
See your plan administrator for more details.

ComPsych Corporation (ComPsych) is a vendor to The Guardian Life Insurance Company of America (Guardian). ComPsych and Guardian are not affiliated entities. The Employee Assistance Program (Services) is provided by ComPsych. Guardian does not control or provide any part of the Services and does not bear any liability for their provision. This informational resource is not a contract and is for illustrative purposes only. Only the policy contains applicable terms. Guardian and ComPsych reserve the right to discontinue Services at anytime without notice. Services may not be available in all states. Legal/financial assistance and resources services are not available in the states of New York and Hawaii. Provision of Services shall be in a manner consistent with applicable law.

2024-167514 (1/26)

Guardian

Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

Important information

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.
Visit **https://www.guardiananytime.com/notice48** to read more.

No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.
Visit **https://www.guardiananytime.com/notice46** to read more.

Vision insurance

Guardian's HIPAA Notice of Privacy Practices

The notice describes how health information about you may be used and disclosed and how you can access this information.
Visit **https://www.guardiananytime.com/notice50** to read more.

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

Please print clearly and mark carefully.

Employer/Planholder Name: **HIGHLAND COUNTY**	Group Plan Number: **00564909**	Benefits Effective:_____

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

In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term , and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.

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

About You:

Full Legal Name-First, MI, Last Name:

What is the name you go by? (optional)

Employer/Planholder 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 Identity: ❑ M ❑ F Date of Birth (mm-dd-yy): ____ - ____ - ____

Phone (indicate primary): ❑ Home (____) ____ - ____
❑ Work (____) ____ - ____
❑ Mobile (____) ____ - ____

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

Are you married or in a civil union? ❑ Yes ❑ No Date of marriage/civil 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/Family Members you wish to enroll. You can enroll only those Dependents/Family Members that are eligible for coverage. Please refer to the plan documents such as the group policy, member guide, or certificate to determine if a Dependent/Family Member is eligible for coverage.

If additional space is needed, please attach a separate page with this information along with your enrollment form. Each Dependent/Family Member's Social Security Number must be provided if enrolling them for Life Coverage. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a niece or a nephew.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Jul 01, 2026

Spouse Address/City/State/Zip: Phone: ( ) -		Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender Identity: ❑ M ❑ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent State of Residence:_____

Drop Coverage:

❑ Drop Employee/Member ❑ Drop Dependents/Family Members

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:

❑ Vision ❑ Employee/Member ❑ Spouse ❑ Child(ren)

❑ Basic Term Life

❑ Voluntary Term Life ❑ Employee/Member ❑ Spouse ❑ Child(ren)

Loss Of Other Coverage:

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

❑ Termination of Employment: _____-_____-_____

❑ Divorce/Separation _____-_____-_____

❑ Death of Spouse _____-_____-_____

❑ Termination/Expiration of Coverage _____-_____-_____

Coverage Lost ❑ 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)

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

Your Bi-weekly Premium	Employee/Member Only	Employee/Member, Spouse & Dependent/Child(ren)
Full Feature	❑ $1.30	❑ $3.58

❑ I do not want this Vision coverage because (Check as applicable):

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

Guardian Group Plan Number: **00564909** Please print employee name:

Basic Life Coverage with Accidental Death and Dismemberment (AD&D):

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.

Policy Amount
Employee/Member Only
☑ $15,000
The Guarantee Issue Amount is $15,000.

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

Employee/Member 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/Member:**_____

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

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

Phone: ( ) - **Relationship to Employee/Member:**_____

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

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

Phone: ( ) - **Relationship to Employee/Member:**_____

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

Dependents/Family Members – If the intended beneficiary is to be someone other than the Employee/Member, 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 coverage will replace your existing life insurance coverage through your current Employer/Planholder, 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.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D): **You must be enrolled to cover your dependents/family members.** ***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.

Employee/Member

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					

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**

Policy Amount

❑ $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 $25,000*, 65-69 $10,000, 70+ $0.

****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

❑ $1,000	❑ $2,000	❑ $3,000	❑ $4,000	❑ $5,000	❑ $6,000
❑ $7,000	❑ $8,000	❑ $9,000	❑ **$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.**

LIFE INSURANCE *continued*

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term 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/Member:**_____

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

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

Phone: ( ) - **Relationship to Employee/Member:**_____

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

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

Phone: ( ) - **Relationship to Employee/Member:**_____

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

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, 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 dependents/family members 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/family member, other than a newborn child, will not take effect if that dependent/family member is confined to a hospital or other health care facility, or is home confined, or is unable to perform two or more Activities of Daily Living (ADL's).
- 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.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.
- Your coverage will not be effective until approved by a 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.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder 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 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 is guilty of insurance fraud.

SIGNATURE OF EMPLOYEE/MEMBER 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 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.

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 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.

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.

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.