

COMPANY PAID LIFE/ VOLUNTARY LIFE/ VOLUNTARY SHORT AND LONG TERM  
DISABILITY



Employer:  
**Southern Design Services Incorporated**  
110 Carpet Drive  
Spartanburg, SC 29303

Guardian Group Plan Number: **441370**

The Guardian Life Insurance Company of America

<b>EMPLOYER USE ONLY</b> <input checked="" type="checkbox"/> New Application <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Drop Dependent(s) <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name <input type="checkbox"/> Drop Coverage as of: / /			
Hours Worked	40	Division	N/A
Benefits Effective			09 / 01 / 2008
Keep a copy for your records and return form to: <b>Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012</b>			

<b>ABOUT YOURSELF</b> <i>Print clearly in black or blue ink.</i>			
First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> E-mail <input type="checkbox"/> Day Phone <input type="checkbox"/> Eve Phone
Job Title	Work Status <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation	Date work status began / /	Annual Salary/Earnings \$
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>ABOUT YOUR DEPENDENTS</b> <input type="checkbox"/> A sheet with information about additional dependents is attached.			
Spouse First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -
Child 1 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school): City/State: Attending Since / /
Child 2 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school): City/State: Attending Since / /
Child 3 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school): City/State: Attending Since / /
Child 4 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> 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. <input type="checkbox"/> Basic Life <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Short Term Disability			

<b>YOUR BASIC LIFE COVERAGE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&amp;D)</b>	
Policy Amount	Employee <input checked="" type="checkbox"/> \$10,000
If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy \$ <u>N/A</u>	

**DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER**  
DATE FORM PUBLISHED: Sep 04, 2008

**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		Check one box only
<b>Employee</b>	<b>Policy Amount</b>	You must be enrolled to cover your dependents.
See Illustration 1 for price.	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$60,000	
	<input type="checkbox"/> \$70,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$100,000* <input type="checkbox"/> \$110,000 <input type="checkbox"/> \$120,000	
	<input type="checkbox"/> \$130,000 <input type="checkbox"/> \$140,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$160,000 <input type="checkbox"/> \$170,000 <input type="checkbox"/> \$180,000	
	<input type="checkbox"/> \$190,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$210,000 <input type="checkbox"/> \$250,000	
	<i>*Guarantee Issue Amount</i>	
<input type="checkbox"/> I waive this coverage		

Add Voluntary Life for Spouse	<i>Check one box only</i>
	<input type="checkbox"/> 50% of employee's amount to maximum \$125,000
<input type="checkbox"/> I waive this coverage <b>The amount may not be more than 50% of the employee amount for Voluntary Life.</b>	

Add Voluntary Life for Child(ren)	<i>Check one box only</i>
	<input type="checkbox"/> 10% of employee's amount to maximum \$10,000
<input type="checkbox"/> I waive this coverage <b>The amount may not be more than 10% of the employee amount for Voluntary Life.</b>	

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, an Evidence of Insurability form must be completed for any amount above the Guarantee Issue.**

**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.

CHOOSE YOUR SHORT-TERM DISABILITY (STD) COVERAGE	
<i>Weekly Benefit</i>	
<input type="checkbox"/> \$100.00	<b>** See Illustration 2 for price.**</b>
<input type="checkbox"/> \$300.00	
<input type="checkbox"/> \$500.00	
<input type="checkbox"/> \$700.00	
<input type="checkbox"/> \$900.00	
<input type="checkbox"/> \$1,100.00	
<input type="checkbox"/> \$1,300.00	
<input type="checkbox"/> I waive this coverage.	

**CHOOSE YOUR LONG-TERM DISABILITY (LTD) COVERAGE**

*Monthly Benefit*

- \$250.00
  - \$500.00      **\*\* See Illustration 3 for prices. \*\***
  - \$1,000.00
  - \$2,000.00
  - \$3,000.00
  - \$4,000.00
  - \$5,000.00
- I waive this coverage.

**IMPORTANT NOTES**

- Paying for disability income insurance pre-tax may cause the benefits to be taxable to the recipient at the time of payment.

**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**

# Life Cost Illustration

## VOLUNTARY LIFE

### Illustration 1

#### Voluntary Life Cost Illustration

Weekly premiums displayed.  
Policy Election Cost Per Age Bracket

	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
<b>10,000 Policy Election Amount</b>										
Employee	\$16	\$16	\$16	\$23	\$35	\$53	\$83	\$141	\$229	\$372
Spouse	\$08	\$08	\$08	\$12	\$17	\$27	\$42	\$70	\$114	\$186
Child	\$04	\$04	\$04	\$04	\$04	\$04	\$04	\$04	\$04	\$04
<b>\$20,000 Policy Election Amount</b>										
Employee	\$32	\$32	\$32	\$46	\$69	\$106	\$166	\$282	\$457	\$743
Spouse	\$16	\$16	\$16	\$23	\$35	\$53	\$83	\$141	\$229	\$372
Child	\$08	\$08	\$08	\$08	\$08	\$08	\$08	\$08	\$08	\$08
<b>\$30,000 Policy Election Amount</b>										
Employee	\$49	\$49	\$49	\$69	\$104	\$159	\$249	\$422	\$685	\$1115
Spouse	\$24	\$24	\$24	\$35	\$52	\$80	\$125	\$211	\$343	\$557
Child	\$12	\$12	\$12	\$12	\$12	\$12	\$12	\$12	\$12	\$12
<b>\$40,000 Policy Election Amount</b>										
Employee	\$65	\$65	\$65	\$92	\$139	\$212	\$332	\$563	\$914	\$1486
Spouse	\$32	\$32	\$32	\$46	\$69	\$106	\$166	\$282	\$457	\$743
Child	\$16	\$16	\$16	\$16	\$16	\$16	\$16	\$16	\$16	\$16
<b>\$50,000 Policy Election Amount</b>										
Employee	\$81	\$81	\$81	\$115	\$173	\$265	\$415	\$704	\$1142	\$1858
Spouse	\$40	\$40	\$40	\$58	\$87	\$133	\$208	\$352	\$571	\$929
Child	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20	\$20
<b>\$60,000 Policy Election Amount</b>										
Employee	\$97	\$97	\$97	\$139	\$208	\$319	\$499	\$845	\$1371	\$2229
Spouse	\$49	\$49	\$49	\$69	\$104	\$159	\$249	\$422	\$685	\$1115
Child	\$24	\$24	\$24	\$24	\$24	\$24	\$24	\$24	\$24	\$24
<b>\$70,000 Policy Election Amount</b>										
Employee	\$113	\$113	\$113	\$162	\$242	\$372	\$582	\$985	\$1599	\$2601
Spouse	\$57	\$57	\$57	\$81	\$121	\$186	\$291	\$493	\$800	\$1300
Child	\$28	\$28	\$28	\$28	\$28	\$28	\$28	\$28	\$28	\$28
<b>\$80,000 Policy Election Amount</b>										
Employee	\$129	\$129	\$129	\$185	\$277	\$425	\$665	\$1126	\$1828	\$2972
Spouse	\$65	\$65	\$65	\$92	\$139	\$212	\$332	\$563	\$914	\$1486
Child	\$31	\$31	\$31	\$31	\$31	\$31	\$31	\$31	\$31	\$31
<b>\$90,000 Policy Election Amount</b>										
Employee	\$145	\$145	\$145	\$208	\$312	\$478	\$748	\$1267	\$2056	\$3344
Spouse	\$73	\$73	\$73	\$104	\$156	\$239	\$374	\$634	\$1028	\$1672
Child	\$35	\$35	\$35	\$35	\$35	\$35	\$35	\$35	\$35	\$35

Voluntary Life Cost Illustration *continued*

	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
<b>\$100,000 Policy Election Amount</b>										
Employee	\$162	\$162	\$162	\$231	\$346	\$531	\$831	\$1408	\$2285	\$3715
Spouse	\$81	\$81	\$81	\$115	\$173	\$265	\$415	\$704	\$1142	\$1858
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$110,000 Policy Election Amount</b>										
Employee	\$178	\$178	\$178	\$254	\$381	\$584	\$914	\$1549	\$2513	\$4087
Spouse	\$89	\$89	\$89	\$127	\$190	\$292	\$457	\$774	\$1257	\$2044
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$120,000 Policy Election Amount</b>										
Employee	\$194	\$194	\$194	\$277	\$415	\$637	\$997	\$1689	\$2742	\$4459
Spouse	\$97	\$97	\$97	\$139	\$208	\$319	\$499	\$845	\$1371	\$2229
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$130,000 Policy Election Amount</b>										
Employee	\$210	\$210	\$210	\$300	\$450	\$690	\$1080	\$1830	\$2970	\$4830
Spouse	\$105	\$105	\$105	\$150	\$225	\$345	\$540	\$915	\$1485	\$2415
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$140,000 Policy Election Amount</b>										
Employee	\$226	\$226	\$226	\$323	\$485	\$743	\$1163	\$1971	\$3199	\$5202
Spouse	\$113	\$113	\$113	\$162	\$242	\$372	\$582	\$985	\$1599	\$2601
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$150,000 Policy Election Amount</b>										
Employee	\$242	\$242	\$242	\$346	\$519	\$796	\$1246	\$2112	\$3427	\$5573
Spouse	\$121	\$121	\$121	\$173	\$260	\$398	\$623	\$1056	\$1714	\$2787
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$160,000 Policy Election Amount</b>										
Employee	\$259	\$259	\$259	\$369	\$554	\$849	\$1329	\$2252	\$3655	\$5945
Spouse	\$129	\$129	\$129	\$185	\$277	\$425	\$665	\$1126	\$1828	\$2972
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$170,000 Policy Election Amount</b>										
Employee	\$275	\$275	\$275	\$392	\$589	\$902	\$1412	\$2393	\$3884	\$6316
Spouse	\$137	\$137	\$137	\$196	\$294	\$451	\$706	\$1197	\$1942	\$3158
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$180,000 Policy Election Amount</b>										
Employee	\$291	\$291	\$291	\$415	\$623	\$955	\$1495	\$2534	\$4112	\$6688
Spouse	\$145	\$145	\$145	\$208	\$312	\$478	\$748	\$1267	\$2056	\$3344
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$190,000 Policy Election Amount</b>										
Employee	\$307	\$307	\$307	\$439	\$658	\$1009	\$1579	\$2675	\$4341	\$7059
Spouse	\$154	\$154	\$154	\$219	\$329	\$504	\$789	\$1337	\$2170	\$3530
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$200,000 Policy Election Amount</b>										
Employee	\$323	\$323	\$323	\$462	\$692	\$1062	\$1662	\$2815	\$4569	\$7431
Spouse	\$162	\$162	\$162	\$231	\$346	\$531	\$831	\$1408	\$2285	\$3715
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39
<b>\$210,000 Policy Election Amount</b>										
Employee	\$339	\$339	\$339	\$485	\$727	\$1115	\$1745	\$2956	\$4798	\$7802
Spouse	\$170	\$170	\$170	\$242	\$364	\$557	\$872	\$1478	\$2399	\$3901
Child	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39	\$39

**Voluntary Life Cost Illustration** *continued*

	< 25    25-29    30-34    35-39    40-44    45-49    50-54    55-59    60-64    65-69†										
<b>\$250,000 Policy Election Amount</b>											
Employee	\$250,000	\$4.04	\$4.04	\$4.04	\$5.77	\$8.65	\$13.27	\$20.77	\$35.19	\$57.12	\$92.89
Spouse	\$125,000	\$2.02	\$2.02	\$2.02	\$2.89	\$4.33	\$6.64	\$10.39	\$17.60	\$28.56	\$46.44
Child	\$10,000	\$ .39	\$ .39	\$ .39	\$ .39	\$ .39	\$ .39	\$ .39	\$ .39	\$ .39	\$ .39

\* Guarantee Issue Amount: Employee \$100,000; Spouse \$25,000; Child \$10,000

† Estimated premiums; refer to your first paycheck deduction for final rates. Your company has selected Guardian to provide life coverage to eligible employees according to plan terms which have been mutually agreed upon. As an eligible employee, you can purchase this coverage at the group premium levels illustrated above. For more details see enrollment form.

Subject to coverage limits

Premiums for Voluntary Life Increase in 5 year increments

Spouse coverage is based on employee age and terminates at age 70.

† Benefit reductions apply. See plan details

# Short-Term Disability Plan Weekly Cost Illustration

SHORT TERM DISABILITY COSTS

\* Illustration 2\*

Weekly Benefit	Election Cost Per Age Bracket										
	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+		
\$100 Weekly Benefit	\$1.45	\$1.45	\$1.49	\$1.53	\$1.57	\$1.61	\$1.65	\$1.98	\$2.53		
\$300	\$4.36	\$4.36	\$4.47	\$4.59	\$4.71	\$4.83	\$4.94	\$5.95	\$7.60		
\$500	\$7.26	\$7.26	\$7.45	\$7.65	\$7.85	\$8.04	\$8.24	\$9.91	\$12.66		
\$700	\$10.16	\$10.16	\$10.44	\$10.71	\$10.99	\$11.26	\$11.53	\$13.88	\$17.72		
\$900	\$13.06	\$13.06	\$13.42	\$13.77	\$14.12	\$14.48	\$14.83	\$17.84	\$22.78		
\$1,100	\$15.97	\$15.97	\$16.40	\$16.83	\$17.26	\$17.69	\$18.13	\$21.81	\$27.85		
\$1,300	\$18.87	\$18.87	\$19.38	\$19.89	\$20.40	\$20.91	\$21.42	\$25.77	\$32.91		

\* This benefit may not exceed 60% of your weekly salary.

**Short Term Disability General Limitations and Exclusions:** We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces); committing a felony or taking part in any riot or other civil disorder; or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for any job-related or on-the-job injury, or conditions for which Workers' Compensation benefits are payable. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, and the employee's loss or earnings is not solely due to disability. This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department. 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 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations. If the plan is new (not transferred). This STD plan limits benefits to two weeks for a disability relating to a pre-existing condition. Contract #'s GP-1-STD2K-1.0 et al.

*This handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails. Your company has selected Guardian to provide disability coverage to eligible employees according to plan terms which have been mutually agreed upon. As an eligible employee, you can purchase this coverage at the group premium levels illustrated above.*

To determine Pre Tax weekly cost match the weekly benefit amount to your age to determine the cost.

\*\*Example: A weekly benefit of \$900.00 for a 40 year old will be a pre tax cost of \$14.12 per week.

The benefit options shown are the only options available.

## LONG TERM DISABILITY COSTS

### Illustration 3

#### **Weekly Long Term Disability Age-Banded Rates**

Coverge Amount	<30	30-34	35-39	40-44	45-49	50-54	55-59	60+
\$250	\$0.10	\$0.19	\$0.25	\$0.31	\$0.46	\$0.77	\$1.02	\$1.06
\$500	\$0.20	\$0.39	\$0.49	\$0.61	\$0.91	\$1.53	\$2.04	\$2.13
\$1,000	\$0.39	\$0.77	\$0.98	\$1.22	\$1.83	\$3.07	\$4.09	\$4.25
\$2,000	\$1.07	\$2.27	\$2.94	\$3.52	\$5.35	\$8.87	\$11.84	\$12.36
\$3,000	\$2.01	\$3.88	\$4.92	\$5.95	\$9.14	\$15.16	\$20.28	\$21.25
\$4,000	\$2.77	\$5.45	\$6.92	\$8.40	\$12.74	\$21.23	\$28.43	\$29.72
\$5,000	\$3.69	\$7.15	\$9.12	\$11.08	\$16.73	\$27.92	\$37.27	\$39.00

To determine your weekly pre tax cost match the the benefit amount to your age to determine the cost.

\*\*Example: A monthly benefit amount of \$3000.00 for a 40 year old is a weekly pre tax cost of \$5.95 per week.

The benefit options shown are the only options available.



COMPLETE ONLY IF YOU ARE REQUESTING MORE THAN \$100,000 OF LIFE OR YOUR SPOUSE IS REQUESTING MORE THAN \$25,000.00

Midwest Regional Office PO Box 8012 Appleton, WI 54912-8012

Northeast Regional Office PO Box 26040 Lehigh Valley, PA 18002-6040

Evidence of Insurability for Group Term Life Insurance

Please complete in ink. Erasures and changes invalidate this form. Group plan #

1. Employee name (last, first, middle):
2. Sex: male female
3. Height/Weight:
4. Birth: mo. day yr.
5. Birth place:
6. Annual earnings:
7. Amt. of Ins.
8. Employer:
9. Occupation
10. Are you requesting insurance for your spouse: yes no if yes complete 11-14. Child(ren): yes no
11. Name of spouse (last, first, middle):
12. Birth: mo. day yr.
13. Height/Weight:
14. Amt. of Ins.

Have you, or your spouse (if covered):

15. ever been rated, declined, for life, accident or health insurance or ever had such insurance postponed, modified or renewal declined, or received disability payments for more than 6 months? Employee yes no Spouse yes no
16. in the past 10 years been treated for or diagnosed as having heart disorder, high blood pressure, diabetes, rheumatic fever, stroke, cancer, tumor, chest pain, asthma, respiratory illness, mental or nervous disorder, blood disorder, gonorrhea, genital herpes, genital warts, syphilis, herpes simplex? Employee yes no Spouse yes no
17. within 10 years ever used drugs other than as prescribed by a physician; been advised to have treatment or been treated for drug abuse or alcoholism? Employee yes no Spouse yes no
18. a) been treated for or diagnosed as having AIDS or AIDS Related Complex? Employee yes no Spouse yes no
b) in the past year had fever persisting more than one (1) month; significant involuntary weight loss; diarrhea persisting more than one (1) month; oral candidiasis (thrush); lymphadenopathy (enlarged or swollen glands)? If yes, provide complete details below. Employee yes no Spouse yes no
19. in the past five years: a) consulted or been examined by or treated by a physician, practitioner or specialist? b) been in a hospital, sanitarium, or other institution for observation, diagnosis, treatment or an operation? c) been prescribed medication(s)? Employee yes no Spouse yes no

For each "yes" answer to questions 15 through 19, give details below:

Table with 7 columns: No., Name, Practitioner's name & address, Hospital name & address, Condition, Duration of symptoms, treatment & degree of recovery, Dates, mo./yr.

Use separate sheet if additional space is needed. Be certain to read, sign, date and have this application witnessed on the reverse side.

Endorsement by The Guardian Life Insurance Company of America Group plan # G-

Employee is: approved rejected Amt. Spouse is: approved rejected Amt. Child(ren) is: approved Amt.
Risk classification (excess Life): Effective: mo. day yr. Secretary: [Signature]
AMG-010227 (10/05) Date: [Signature] By:

TEAR OFF

IMPORTANT: read and detach for your records

Thank you for choosing Guardian insurance. This notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Corporate Secretary, Guardian Life Insurance Company of America, 7 Hanover Square, New York, N.Y. 10004-4025.

findings about you to the Bureau. We will not report what action we have taken on your application.

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. But medical information will be disclosed only to your doctor. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is Post Office Box 105, Essex Station, Boston, MA 02112, telephone 617-426-3660.

Medical Information Bureau Pre-notice: The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. On the request of any of its member companies to which you apply for life or health insurance, or to which you make a claim for benefits, the Bureau will supply the inquiring company with the information in its files.

Medical Records: We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

Guardian or our reinsurers may make a brief report of objective

**Important: Must be Signed Twice By Applicant.**

**I hereby represent that the statements and answers to questions above are, to the best of my knowledge and belief, full, complete and true. I understand that they shall form the basis upon which I may be included for insurance.**

Furthermore it is mutually understood and agreed that (1) the insurance Company reserves the right to request, at the Insurance Company's expense, I be examined by an accredited medical examiner selected by the insurance Company, (2) no Group Insurance shall be binding or in force until satisfactory evidence of insurability is submitted and approved by the Insurance Company at the Home Office as shown in the Endorsement below, and I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise I will become insured on the date I do return to work and satisfy these requirements, (3) no person, except the President, a Vice President or a Secretary of the Company, has authority to determine whether any contract(s) of insurance shall be issued on the basis of the application, to waive or modify any of the provisions of the application or any of the Company's requirements, to bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application, or to accept any information or representation not contained in the written application; (4) the employer is hereby designated the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

**I have read both sides of this application including the Pre-Notices concerning the Medical Information Bureau copies of which have been received by me.**

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed by

**INSURANCE INFORMATION PRACTICES –  
MEDICAL RECORDS AND OTHER INFORMATION**

**I authorize** any physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my minor children to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my minor children.

**I understand** The Guardian Life Insurance Company of America will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization *except* to reinsurance company, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be lawfully permitted or required, or as I may further authorize.

**I know** that I may request and receive a copy of this authorization.

**I agree** that a photocopy of this authorization shall be as valid as the original.

**I acknowledge** receipt of Guardian's notice regarding its Insurance Information Practices, and Medical Records.

**I agree** that this authorization shall be valid for two and one half years from the date shown below.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of spouse