



YOUR GROUP INSURANCE PLAN BENEFITS

TOWN OF CONCORD

CLASS 0001 0003

AD&D, VOLUNTARY AD&D, OPTIONAL LIFE, LIFE, VOLUNTARY LTD

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000
www.GuardianAnytime.com

If Your Group Certificate includes any of the following coverages: Guardian Insured: Group Accident, Group Cancer, Group Critical Illness, Group Hospital Indemnity, Group Dental or Group Vision, the following consumer complaint notice is applicable. (Employer Funded Coverages, if any, are excluded from this Rider.)

New Mexico Residents
Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

<http://www.osi.stat.nm.us/ConsumerAssistance/index.aspx>

CCN-2019-NM

B999.0042

CERTIFICATE OF COVERAGE

The Guardian

*7 Hanover Square
New York, New York 10004*

Guardian certifies that the employee to whom this certificate is issued is entitled to the benefits described herein. However, the employee must: (a) satisfy all of this plan's eligibility and effective date requirements; and (b) be listed in the employer's records as a validly covered employee under this plan. And all required premium payments must have been made by, on or on behalf of the employee.

The employee and/or his or her dependents are not covered by any part of this plan for which he or she has waived coverage. Such waiver of coverage is shown in the planholder's records.

Group Plan No. 399266

This Certificate of Coverage describes the essential features of this plan of insurance. It does not waive or alter any terms of the group policy and the planholder's Employer Rider. If any questions arise, the group policy and the planholder's Employer Rider will govern.

This certificate of coverage replaces any certificate of coverage previously issued under the above plan number or under any plan providing identical or similar benefits issued to the planholder by Guardian.



Michael Prestileo, Senior Vice President

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GENERAL PROVISIONS

As used in this booklet:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, out-of-network point-of-service, prescription drug, surgical, vision care or weekly loss-of-time insurance provided by this *plan*.

"Covered person" means an *employee* or a dependent insured by this *plan*.

"Employer" means the *employer* who purchased this *plan*.

"Our," "The Guardian," "us" and "we" mean The Guardian Life Insurance Company of America.

"Plan" means the Guardian *plan* of group insurance purchased by your *employer*.

"You" and "your" mean an *employee* insured by this *plan*.

CGP-3-R-GENPRO-90

B160.0002

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, plan or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or plan, or any requirements of The Guardian; (c) bind us by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

CGP-3-R-LOA-90

B160.0004

Incontestability

This *plan* is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this *plan* shall be used in contesting the validity of his insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his lifetime.

If this *plan* replaces a plan your *employer* had with another insurer, we may rescind the *employer's plan* based on misrepresentations made by the *employer* or an *employee* in a signed application for up to two years from the effective date of this *plan*.

CGP-3-R-INCY-90

B160.0003

Examination and Autopsy

We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90

B160.0006

Accident and Health Claims Provisions

Your right to make a claim for any *accident and health* benefits provided by this *plan*, is governed as follows:

Notice You must send us written notice of an *injury* or *sickness* for which a claim is being made within 20 days of the date the *injury* occurs or the *sickness* starts. This notice should include your name and *plan* number.

Proof of Loss We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 90 days of the loss.

Late Notice of Proof We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

Payment of Benefits We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled as soon as we receive written proof of loss.

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

When you file proof of loss, you may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

Accident and Health Claims Provisions (Cont.)

Limitations of Actions You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after three years from the date you file proof of loss.

Workers' Compensation The *accident and health* benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CGP-3-R-AHC-90

B160.0014

YOUR CONTINUATION RIGHTS

Your right to continue coverage under this plan is governed as follows.

When You Can Continue

If You Leave The Group If you leave the group covered by this plan, you will remain insured for all group benefits provided by this plan, except for group term life insurance, until the earlier of:

- the end of a 31 day period which starts on the date your group benefits would otherwise end; or
- the date you become eligible for similar benefits.

CGP-3-R-CC-MA-91-2

B240.0138

ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES

B264.0003

Employee Coverage

Eligible Employees To be eligible for employee coverage, you must be an active *full-time employee* or a *qualified retiree*. And you must belong to a class of *employees* covered by this *plan*.

Other Conditions If you must pay all or part of the cost of employee coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

If your active *full-time* service ends before you meet any *proof of insurability* requirements that apply to you, you'll still have to meet those requirements if you're later re-employed.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. The Life Schedule explains if and when we require *proof*. You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

CGP-3-EC-90-1.0

B264.0066

When Your Coverage Starts *Employee* benefits that don't require *proof* that you are insurable are scheduled to start on your effective date.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be actively at work on a *full-time* basis unless you are a *qualified retiree*, on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are an active *full-time employee* and are not actively at work on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you return to active *full-time* work.

If you are a *qualified retiree*, you can not be confined in a health care facility on the scheduled effective date of coverage. If you are confined on that date, we will postpone your coverage until the day after you are discharged. And you must also have met all of the applicable conditions of eligibility and any applicable waiting period in order for coverage to start.

Sometimes, your effective date is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on a *full-time* basis on your last regularly scheduled work day.

CGP-3-EC-90-2.0

B264.3204-R

Employee Coverage (Cont.)

Delayed Effective Date For Employee Optional Life Coverage With respect to this *plan's* employee optional group term life insurance, if an *employee* is not actively at work on a *full-time* basis on the date his or her coverage is scheduled to start, due to *sickness* or *injury*, we'll postpone coverage for an otherwise covered loss due to that condition. We'll postpone such coverage until he or she completes 10 consecutive days of active *full-time* service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date the *employee* returns to active *full-time* service.

CGP-3-DEF-97

B270.0384

When Your Coverage Ends If you are an active *full-time employee*, your coverage ends on the date your active *full-time* service ends for any reason. Such reasons include disability, death, retirement (except for *qualified retirees*), layoff, leave of absence and the end of employment. If you are a *qualified retiree*, your optional life coverage ends at age 75.

If you are an active *full-time employee* or a *qualified retiree*, your coverage also ends on the date you stop being a member of a class of employees eligible for insurance under this plan, or when this plan ends for all *employees*. And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

If you are required to pay all or part of the cost of this *coverage* and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time. And you may have the right to replace certain group benefits with converted policies.

CGP-3-EC-90-3.0

B264.0014-R

Your Right To Continue Group Life Insurance During A Family Leave Of Absence

Important Notice This section may not apply. You must contact your *employer* to find out if your *employer* must allow for a leave of absence under federal law. In that case the section applies.

Continuation of Coverage Life and Accidental Death and Dismemberment insurance may be continued at your employer's option. You must contact your employer to find out if you may continue this insurance.

If Your Group Coverage Would End Group insurance may normally end for an *employee* because he or she ceases work due to an approved leave of absence. But, the *employee* may continue his or her group insurance if the leave of absence has been granted: (a) to allow the *employee* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the *employee's* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the *employee* is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The *employee* will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends Insurance may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan*.
- The end of the period for which the premium has been paid.

Definitions As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee*.

- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0

B264.2450

Dependent Life Coverage

CGP-3-DEP-90-1.0

B264.0056

Dependent Coverage

Eligible Dependents For Optional Dependent Life Benefits Your *eligible dependents* are: your legal spouse who is under age 70; and your unmarried dependent children who are 14 or more days old, until they reach age 23 and your unmarried dependent children, from age 23 until they reach age 25, who are enrolled as full-time students at accredited schools.

CGP-3-DEP-90-3.0

B264.0579

Adopted Children And Step-Children Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible We exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0

B264.0587

Proof Of Insurability We require *proof* that a dependent is insurable, if you: (a) enroll a dependent and agree to make the required payments after the end of the *enrollment period*; (b) in the case of a newly acquired dependent, other than the first newborn child, have other eligible dependents who you have not elected to enroll; or (c) in the case of a *newly acquired dependent*, have other *eligible dependents* whose coverage previously ended because you failed to make the required contributions, or otherwise chose to end such coverage.

A dependent is not insured by any part of this *plan* that requires such *proof* until you give us this *proof*, and we approve it in writing.

If the dependent coverage ends for any reason, including failure to make the required payments, your dependents won't be covered by this *plan* again until you give us new *proof* that they're insurable and we approve that *proof* in writing.

CGP-3-DEP-90-5.0

B200.0288

Dependent Coverage (Cont.)

When Dependent Coverage Starts

In order for your dependent coverage to begin you must already be insured for employee coverage, or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this *plan*, the date your dependent coverage starts depends on when you elect to enroll your *initial dependents* and agree to make any required payments.

If you do this on or before your *eligibility date*, the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows your *eligibility date* and the date you become insured for employee coverage.

If you do this within the *enrollment period*, the coverage is scheduled to start on the later of the first of the month which coincides with or next follows the date you sign the enrollment form; and the date you become insured for employee coverage.

If you do this after the *enrollment period* ends, your dependent coverage is subject to *proof of insurability* and won't start until we approve that *proof* in writing.

Once you have dependent coverage for your *initial dependents*, you must notify us when you acquire any new dependents and agree to make any additional payments required for their coverage.

A *newly acquired dependent* will be covered for those dependent benefits not subject to *proof of insurability* from the later of the date you notify us and agree to make any additional payments, and the date the *newly acquired dependent* is first eligible.

If *proof of insurability* is required for dependent benefits as explained above, those benefits are scheduled to start, subject to the "Exception" stated below, on the effective date shown in the "Endorsement" section of your application, provided that you send us the *proof* we require and we approve that *proof* in writing. A copy of the approved application is furnished to you.

CGP-3-DEP-90-6.0

B200.0314

Exception If a dependent, other than a newborn child, is confined to a *hospital* or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

CGP-3-DEP-90-7.0

B200.0692

When Dependent Coverage Ends

Dependent coverage ends for all of your dependents when your employee coverage ends. Dependent coverage also ends for all of your dependents when you stop being a member of a class of *employees* eligible for such coverage. And it ends when this *plan* ends, or when dependent coverage is dropped from this *plan* for all *employees* or for an *employee's* class.

If you are required to pay part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Dependent Coverage (Cont.)

An individual dependent's coverage ends when he stops being an *eligible dependent*. This happens to a child at 12:01 a.m. on the date the child attains this *plan's* age limit, when he marries, or when a step-child is no longer dependent on the employee for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment, and with respect to optional life coverage, it happens at 12:01 a.m. on the date the spouse reaches age 75.

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And they may have the right to replace certain group benefits with converted policies.

CGP-3-DEP-90-9.0

B200.0792-R

GROUP TERM LIFE INSURANCE SCHEDULE

CGP-3-R-SCH-90

B265.0002

Employee Basic Term Life Insurance

CGP-3-R-SCH-90

B265.0003

Your Basic Term Life Insurance Amount	Insurance Amount	\$5,000.00
	CGP-3-R-SCH-90	B265.0011

Employee Basic Accidental Death and Dismemberment Insurance (AD&D)

CGP-3-R-SCH-90

B265.0029

Your Basic AD&D Insurance Amount	Insurance Amount	\$5,000.00
	CGP-3-R-SCH-90	B265.0031

Employee Optional Contributory Term Life Insurance

CGP-3-R-SCH-90

B265.0055

Optional Life Election	You may choose to be insured under the plan of optional term life insurance shown below. You must notify the employer of your election and pay the required premium.
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CGP-3-R-SCH-90	B265.0799
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Your Optional Term Life Insurance Amount	Plan A
	You may elect amounts of optional term life insurance in increments of \$5,000.00, but your amount may not be less than \$5,000.00 and may not exceed the lesser of: (1) \$70,000.00; (2) 1 times your annual salary.

CGP-3-R-SCH-90	B265.0063-R
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Proof of Insurability Requirements	Proof of insurability requirements apply to your optional term life insurance. Such requirements may apply to your full benefit amount or just part of it. When <i>proof of insurability</i> requirements apply, it means you must submit to us <i>proof</i> that you're insurable, and we must approve your <i>proof</i> in writing before your insurance, or the specified part becomes effective.
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We require *proof* as follows:

CGP-3-R-SCH-90	B265.0431
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We require *proof* before an *employee* switches from his or her current increment of optional term life insurance to an increment which provides a greater amount of insurance.

CGP-3-R-SCH-90	B265.0732
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Employee Optional Contributory Term Life Insurance (Cont.)

We require *proof* before we will insure any *employee* who enrolls for optional term life insurance after the time allowed for enrolling as specified in this *plan*.

CGP-3-R-SCH-90

B265.0435

We require *proof* for amounts of optional term life insurance in excess of \$10,000.00, if an *employee's* scheduled optional term life effective date is after he or she reaches age 65.

CGP-3-R-SCH-90

B265.0697

Employee Voluntary Accidental Death and Dismemberment Insurance (AD&D)

CGP-3-R-SCH-90

B265.0443

Voluntary AD&D Enrollment Period

You may choose to be insured under the plan of voluntary AD&D insurance shown below. You must notify the employer of your election and pay the required premium.

CGP-3-R-SCH-90

B265.0926

Your Voluntary AD&D Insurance Amount

Plan A

You may elect amounts of voluntary AD&D insurance in increments of \$5,000.00, but your amount may not be less than \$5,000.00 and may not exceed the lesser of: (1)\$70,000.00; (2) 1 times your annual salary. (2)

CGP-3-R-SCH-90

B265.0251-R

Proof of Insurability Requirements

Proof of insurability requirements apply to your voluntary AD&D insurance. Such requirements may apply to your full *benefit amount* or just part of it. When *proof of insurability* requirements apply, it means you must submit to us *proof* that you're insurable, and we must approve your *proof* in writing before your insurance, or the specified part becomes effective.

CGP-3-R-SCH-90

B265.0444-R

Dependent Optional Term Life Insurance

Dependent Optional Life Election

You may choose the plan of dependent spouse optional term life insurance, and the plan of dependent child optional term life insurance shown below. You must notify the employer of your elections and pay the required premium.

CGP-3-R-SCH-90

B265.0800

Your Optional Dependent Spouse Term Life Insurance Amount

Plan A

\$5,000.00

CGP-3-R-SCH-90

B265.0504

Dependent Optional Term Life Insurance (Cont.)

Your Optional Dependent Child Insurance Amount	Plan A Child's Age At Death	Benefit Amount
	At least 14 days but less than 6 months	\$ 400.00
	At least 6 months but less than 23 years	\$ 2,000.00
	At least 23 years but less than 25 years if a full-time student	\$ 2,000.00
	CGP-3-R-SCH-90	B265.0655

**Proof of Insurability
Requirements**

Proof of insurability requirements apply to your dependent optional term life insurance. Such requirements may apply to the full benefits amount or just part of them. When proof of insurability requirements apply, it means you must submit to us proof that a dependent is insurable, and we must approve the proof in writing before the insurance, or the specified part becomes effective.

We require proof as follows:

CGP-3-R-SCH-90 B265.0536

We require proof before we will insure any spouse who is enrolled for dependent optional term life insurance after the time allowed for enrolling as specified in this plan.

CGP-3-R-SCH-90 B265.0540

We require proof before we will insure any child who is enrolled for dependent optional term life insurance after the time allowed for enrolling as specified in this plan.

CGP-3-R-SCH-90 B265.0549

Your Group Term Life Insurance

- Basic Life Benefit** If you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule.
- Proof of Death** We'll pay this insurance as soon as we receive written proof of death. This should be sent to us as soon as possible.
- Your Beneficiary** You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your *employer* written notice, unless you've assigned this insurance. But the change won't take effect until your *employer* gives you written confirmation of the change.
- If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.
- If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.
- Assigning Your Life Insurance** If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.
- We suggest you speak to your lawyer before you make any assignment. If you decide you want to assign this insurance, ask your *employer* for details or write to us.
- Payment to a Minor or Incompetent** If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.
- Payment of Funeral or Last Illness Expenses** We have the option of paying up to \$250.00 of this insurance to any person who incurs expenses for your funeral or last illness.
- Settlement Option** If you or your beneficiary ask us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

Your Optional Group Term Life Insurance

- Life Benefit** Subject to the limitations and exclusions below, if you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule for the plan of benefits you have elected. Your life benefit may be subject to reductions based on your age. These reductions are also shown in the schedule. Your benefit amount, a portion thereof, or increases in such amount may not become effective until you submit *proof of insurability* to us, and we approve it in writing. These requirements are also shown in the schedule.
- Proof of Death** Subject to all of the terms of this *plan*, we'll pay this insurance as soon as we receive written proof of death which is acceptable to us. This should be sent to us as soon as possible.
- Suicide Exclusion** We pay no benefits if your death is due to suicide, if such death occurs within two years from your employee optional group term life insurance effective date under this *plan*. Also, we pay no increased benefit amount if your death is due to suicide, if such death occurs within two years from the effective date of the increase.
- Seatbelt and Airbag Benefits** If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by \$10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional \$5,000.00, for a total increase of \$15,000.00.
- Your Beneficiary** You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your employer written notice, unless you've assigned this insurance. But the change won't take effect until your employer gives you written confirmation of the change.
- If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his or her share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.
- If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.
- Assigning Your Life Insurance** If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.
- We will recognize an assignee as the owner of the rights assigned only if: (a) the assignment is in writing and signed by you; and (b) a signed or certified copy of the written assignment has been received and approved by us.
- We will not be responsible for legal, tax or other effects of any assignment, or for any benefits we pay under this *plan* before we receive and approve any assignment.
- We suggest you speak to a lawyer before you make any assignment. If you decide you want to assign this insurance, write to us for details.

Your Optional Group Term Life Insurance (Cont.)

Payment to a Minor or Incompetent If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.

Payment of Funeral or Last Illness Expense We have the option of paying up to \$250.00 of this insurance to any person who incurs expenses for your funeral or last illness.

Settlement Option If you or your beneficiary asks us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

CGP-3-R-EOPT-96

B273.0528

Portability Privilege

Applicability This provision applies only to this *plan's* employee and dependent Optional group term life insurance. It does not apply to supplemental life insurance, if any is included in this *plan*. And it does not apply to Accidental Death and Dismemberment Insurance.

Important Restriction You may not elect a portable certificate of coverage unless you have been covered by this group *plan*, or the one it replaced, for employee Optional group term life insurance for at least three consecutive months prior to the date your coverage under this *plan* ends.

Portability Of Optional Group Term Life Insurance You may elect to continue all or part of your employee Optional group term life insurance and dependent Optional group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.

You may port your coverage if coverage under this *plan* ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees.

You may not port your coverage or coverage for any of your dependents, if you: (a) have reached your 70th birthday on the day coverage under this *plan* ends; or (b) are eligible for this *plan's* Optional Group Term Life Insurance Extended Life Benefit.

You may not port your coverage or coverage for any of your dependents if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group *plan*.

You may port: (a) the full amount(s) of your Optional term life insurance as of the day your coverage under this *plan* ends, or (b) 50% of such amount, if such amount under this *plan* is at least \$50,000.00.

Portability Privilege (Cont.)

You may port: (a) the full amount(s) of your dependent Optional term life insurance as of the day your coverage under this *plan* ends; or (b) 50% of such amount(s), if: (i) your dependent spouse amount under this *plan* is at least \$20,000.00; and (ii) your dependent child amount under this *plan* is at least \$4,000.00. However, if you port the full amount of your insurance, any dependent amount(s) ported must be a full amount. And, if you elect to port 50% of your insurance, any dependent amount(s) ported must be 50% of such amount(s).

You may port: (a) your insurance only; (b) your insurance and insurance of your covered spouse; (c) your insurance and the insurance of all of your covered dependents; or (d) if you are a single parent, your insurance and the insurance of all of your covered dependent children. No other combinations will be allowed.

To be eligible to port, a dependent must be insured as of the day your coverage under this *plan* ends.

If You Die While Insured If you die while insured for dependent Optional term life insurance, your spouse may port the insurance of your dependents as described above. But, your spouse and dependents must be insured on the date of death. No dependents will be allowed to port if: (a) there is no surviving spouse; or (b) your surviving spouse has reached his or her 70th birthday on the day you die.

The Portable Certificate Of Coverage You or your surviving spouse can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits; (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group *plan*.

The premium for the portable certificate of coverage will be based on: (a) your and/or your dependent's rate class under this plan; and (b) your or your surviving spouse's age bracket as shown in the Optional Life Portability Coverage Premium Notice.

How To Port To get a portable certificate of coverage, you or your surviving spouse must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this *plan* ends to do this. We won't ask for proof that you are insurable.

Defined Term As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

CGP-3-R-LP-00

B273.0732

Information About Conversion and Portability

No covered person is allowed to convert his or her coverage, and elect a portable certificate of coverage at the same time. If a situation arises in which a covered person would be eligible to both convert and port, he or she may only exercise one of these privileges. A covered person may never be insured under both a converted policy and a portable certificate of coverage at the same time. The covered person should read his or her plan, as well as any related materials carefully before making an election.

CGP-3-R-LPN-95

B270.0326

THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:

B275.0076

Converting This Group Term Life Insurance

If Employment Or Eligibility Ends Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy. Conversion choices are based on your disability status.

If you are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", you can convert to a permanent life insurance policy. You can convert the amount for which you were covered under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy, as explained in the section labeled "Interim Term Insurance". You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

If The Group Plan Ends Or Group Life Insurance Is Dropped Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) \$2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. You can convert the full amount for which you were covered under this plan.

Converting This Group Term Life Insurance (Cont.)

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

The Converted Policy The premium for the converted policy will be based on your age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion. The converted policy does not include disability or dismemberment benefits.

Interim Term Insurance If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium" and (b) have not yet been approved for the Extended Life Benefit, you have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

This Interim term policy is available for only one year from the date you become disabled. During this year, if you are approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, you have not been approved for the Extended Life Benefit, you must convert to an individual permanent life insurance policy, or coverage will end. Premiums for the individual permanent life insurance policy will be based on your age as of the date you convert from the interim term insurance policy.

How And When To Convert To get a converted policy, you must apply to us in writing and pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you are insurable.

Death During The Conversion Period If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.

CGP-3-R-LCONV-99

B275.0064

THE FOLLOWING PROVISION APPLIES TO YOUR OPTIONAL GROUP TERM LIFE INSURANCE:

B275.0077

Converting This Group Term Life Insurance

If Employment Or Eligibility Ends Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy. Conversion choices are based on your disability status.

If you are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", you can convert to a permanent life insurance policy. You can convert the amount for which you were covered under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

Converting This Group Term Life Insurance (Cont.)

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy, as explained in the section labeled "Interim Term Insurance". You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

If The Group Plan Ends Or Group Life Insurance Is Dropped Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) \$2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

The Converted Policy The premium for the converted policy will be based on your age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion. The converted policy does not include disability or dismemberment benefits.

Interim Term Insurance If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium" and (b) have not yet been approved for the Extended Life Benefit, you have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

This Interim term policy is available for only one year from the date you become disabled. During this year, if you are approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, you have not been approved for the Extended Life Benefit, you must convert to an individual permanent life insurance policy, or coverage will end. Premiums for the individual permanent life insurance policy will be based on your age as of the date you convert from the interim term insurance policy.

Converting This Group Term Life Insurance (Cont.)

How And When To Convert To get a converted policy, you must apply to us in writing and pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you are insurable.

Death During The Conversion Period If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.

CGP-3-R-LCONV-99

B275.0064

Your Accelerated Life Benefit

IMPORTANT NOTICE: USE OF THE BENEFIT PROVIDED BY THIS SECTION MAY HAVE TAX IMPLICATIONS AND MAY AFFECT GOVERNMENT BENEFITS OR CREDITORS. YOU SHOULD CONSULT WITH YOUR TAX OR FINANCIAL ADVISOR BEFORE APPLYING FOR THIS BENEFIT.

PLEASE NOTE: THE AMOUNT OF GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT PAID TO YOU.

Accelerated Life Benefit If you have a medical condition that is expected to result in your death within 6 months, you may apply for an Accelerated Life Benefit. An Accelerated Life Benefit is a payment of part of your group term life insurance made to you before you die.

We subtract the gross amount paid to you as an Accelerated Life Benefit from the amount of your group term life insurance under this plan. The remaining amount of your group term life insurance is permanently reduced by the gross amount paid to you.

By "group term life insurance" we mean any Employee Optional Group Term Life Insurance for which you are insured under this plan. "Group term life insurance" does not mean Accidental Death and Dismemberment Benefits, any insurance provided under this plan for covered persons other than you or any scheduled increase in the amount of any Employee Group Term Life Insurance that is due within the 6 month period after the date you apply for the Accelerated Life Benefit.

By "gross amount" we mean the amount of an Accelerated Life Benefit elected by you, before the discount and the processing fee are subtracted.

For the purposes of this provision, "terminal condition" means a medical condition that is expected to result in your death within 6 months.

You may use the Accelerated Life Benefit in any way you choose. But you may receive only one Accelerated Life Benefit during your lifetime. If you live longer than 6 months, or if you recover from the condition, the benefit does not have to be repaid. But the amount of this benefit is not restored to your remaining group term life insurance. And you may not receive another Accelerated Life Benefit if you have a relapse or develop another terminal condition.

Your Accelerated Life Benefit (Cont.)

Maximum Benefit Amount The amount of the Accelerated Life Benefit for which you may apply is based on the amount of group term life insurance for which you are insured on the day before you apply for the benefit. The minimum benefit amount is the lesser of: (a) \$10,000.00; or (b) 50% of the inforce amount. The maximum benefit amount is the lesser of: (a) \$100,000.00; or (b) 50% of the inforce amount.

Discount The amount for which you apply is discounted to the present value in 6 months from the date the benefit is paid, based on the maximum adjustable policy loan interest rate permitted in the state in which your employer is located.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is filed with each state insurance department. This statement is available from The Guardian upon request.

Processing Fee A fee of up to \$150.00 may also be required for the administrative cost of evaluating and processing your Accelerated Life Benefit. This fee is deducted from the amount of the Accelerated Life Benefit paid to you.

Payment of An Accelerated Life Benefit If we approve your application for an Accelerated Life Benefit, we pay the amount you have elected, less the discount and the processing fee. We pay the benefit to you in one lump sum. And what we pay is subject to all of the other terms of this plan.

How And When To Apply To receive the Accelerated Life Benefit, you must send us written proof from a licensed doctor who is operating within the scope of his or her license that your medical condition is expected to result in your death within 6 months of the date of the written medical proof. We must approve such proof in writing before the Accelerated Life Benefit will be paid.

We can have you examined by a doctor of our choice to verify the terminal condition. We'll pay the cost of such examination. We will not pay the Accelerated Life Benefit if our doctor does not verify the terminal condition.

If we approve you to receive an Accelerated Life Benefit, we give you a statement which shows: (a) the amount of the maximum Accelerated Life Benefit for which you are eligible; and (b) the amount by which your group term life insurance will be reduced if you elect to receive the maximum Accelerated Life Benefit; and (c) the amount of the processing fee.

Even if you are receiving an Extended Life Benefit under this plan, you can still apply for an Accelerated Life Benefit. However, once you convert your group term life insurance, the terms of the converted life policy will apply. Any amount to which you could otherwise convert is permanently reduced by the gross amount of the Accelerated Life Benefit paid to you.

Please read "Your Remaining Group Term Life Insurance" provision for restrictions that may apply.

If You Have Assigned Your Group Term Life Insurance If you have already assigned your group term life insurance, according to the terms of this plan, you can't apply for an Accelerated Life Benefit.

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B275.0027

Your Accelerated Life Benefit (Cont.)

If You Are Incompetent If you are determined to be legally incompetent, the person the court appoints to handle your legal affairs may apply for the Accelerated Life Benefit for you.

Your Remaining Group Term Life Insurance The remaining amount of group term life insurance for which you are covered after receiving an Accelerated Life Benefit payment is subject to any increases or cutbacks that would otherwise apply to your insurance. Applicable cutbacks are applied to the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

The premium cost of your remaining coverage is based on the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

You may be required to provide proof of insurability for increased amounts. If you are, we must approve that proof in writing before you are covered for the new amount.

The total amount of group term life insurance your beneficiary would Otherwise receive upon your death is reduced by the gross amount of the Accelerated Life Benefit paid to you.

If you die after electing the Accelerated Life Benefit, but before we send the benefit to you, your beneficiary will receive the amount of the group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

Restrictions We will not pay an Accelerated Life Benefit to you if you:

- are required by law to use the payment to meet the claims of creditors, whether or not you are in bankruptcy; or
- are required by court order to pay all or part of the benefit to another person; or
- are required by a government agency to use the payment to apply for, to receive or to maintain a governmental benefit or entitlement; or
- lose your coverage under the group plan for any reason after you elect the Accelerated Life Benefit but before we pay such benefit to you.

CGP-3-EALB-17-IL

B270.0322

Your Extended Life Benefit With Waiver Of Premium

Important Notice This section applies to your basic life benefit. But, it does not apply to your accidental death and dismemberment benefits; nor to any of your dependent's insurance under this group plan. In order to continue dependent basic life insurance, you must convert your dependent coverage to an individual permanent policy.

If You Are Disabled You are disabled if you meet the definition of total disability, as stated below. If you meet the requirements in the "How and When to Apply" provision, we'll extend your basic life insurance under this section without payment of premiums from you or the employer.

Your Extended Life Benefit With Waiver Of Premium (Cont.)

Total Disability or Totally Disabled means, due to sickness or injury, you are:

- (a) not able to perform any work for wages or profit; and
- (b) you are receiving regular doctor's care appropriate to the cause of disability.

How And When To Apply

To apply for this extension, you must submit satisfactory written medical proof of your total disability within one year of the onset of that disability. Any claim filed after one year from the onset of total disability will be denied, unless we receive written proof that: (a) you lacked the legal capacity to file the claim; or (b) it was not reasonably possible for you to file the claim.

Also, in order to be eligible for this extension, you must:

- (a) become totally disabled before you reach age 60 and while insured by the group plan; and
- (b) remain totally disabled for 09 continuous months.

You are encouraged to apply for this benefit immediately upon the onset of disability.

Continued Eligibility For Extended Life Benefit

We may require periodic written proof that you remain totally disabled to maintain this extension. This written proof of your continued disability and doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary during the first two years we've extended your life benefits. But after two years, we can't have you examined more than once a year.

Until You've Been Approved For This Extended Life Benefit

Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

- (a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or
- (b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

However, if this group plan terminates, and you are totally disabled and eligible, but not yet approved, for this extended benefit, you must convert to an individual permanent or term policy, and remain insured under such policy until you are approved by us for the extended benefit.

Converting does not stop you from claiming your rights under this section. But if you convert and we later approve you for this extended benefit, we'll cancel the converted policy as of our approval date. Once you are approved for this extended benefit, your group term life coverage will be reinstated at no further cost to you or the employer.

Your Extended Life Benefit With Waiver Of Premium (Cont.)

When This Extension Begins Once approved by us, your extended benefit will be effective on the later of:

- (a) 09 continuous months from the date active full-time service ends due to total disability; or
- (b) the date we approve you for this benefit.

CGP-3-R-LW-TD-99-1

B275.0513

When This Extension Ends Your extension will end on the earliest of:

- (a) the date you are no longer disabled;
- (b) the date we ask you to be examined by our doctor, and you refuse;
- (c) the date you do not give us the proof of disability we require;
- (d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or
- (e) the day before the date you reach age 65.

If the extension ends, and you are not insured by the group plan again as an active full-time employee, you can convert as if your employment just ended. Read the section labeled "Converting This Group Term Life Insurance".

If You Die While Covered By This Extension If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee. The benefit amount is also subject to reduction which applies at retirement. We will use your Social Security Normal Retirement Age, as defined in the 1983 amendment to the Social Security Act, to determine when to apply the retirement reduction to your extended life benefit.

Proof Of Death We'll pay as soon as we receive

- (a) written proof of your death, that is acceptable to us; and
- (b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

CGP-3-R-LW-TD-99-2

B275.0070

Your Extended Life Benefit With Waiver Of Premium

Important Notice This section applies to your optional life benefit. But, it does not apply to your accidental death and dismemberment benefits; nor to any of your dependent's insurance under this group plan. In order to continue dependent optional life insurance, you must convert your dependent coverage to an individual permanent policy.

If You Are Disabled You are disabled if you meet the definition of total disability, as stated below. If you meet the requirements in the "How and When to Apply" provision, we'll extend your optional life insurance under this section without payment of premiums from you or the employer.

Your Extended Life Benefit With Waiver Of Premium (Cont.)

Total Disability or Totally Disabled means, due to sickness or injury, you are:

- (a) not able to perform any work for wages or profit; and
- (b) you are receiving regular doctor's care appropriate to the cause of disability.

How And When To Apply

To apply for this extension, you must submit satisfactory written medical proof of your total disability within one year of the onset of that disability. Any claim filed after one year from the onset of total disability will be denied, unless we receive written proof that: (a) you lacked the legal capacity to file the claim; or (b) it was not reasonably possible for you to file the claim.

Also, in order to be eligible for this extension, you must:

- (a) become totally disabled before you reach age 60 and while insured by the group plan; and
- (b) remain totally disabled for 09 continuous months.

You are encouraged to apply for this benefit immediately upon the onset of disability.

Continued Eligibility For Extended Life Benefit

We may require periodic written proof that you remain totally disabled to maintain this extension. This written proof of your continued disability and doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary during the first two years we've extended your life benefits. But after two years, we can't have you examined more than once a year.

Until You've Been Approved For This Extended Life Benefit

Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

- (a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or
- (b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

However, if this group plan terminates, and you are totally disabled and eligible, but not yet approved, for this extended benefit, you must convert to an individual permanent or term policy, and remain insured under such policy until you are approved by us for the extended benefit.

Converting does not stop you from claiming your rights under this section. But if you convert and we later approve you for this extended benefit, we'll cancel the converted policy as of our approval date. Once you are approved for this extended benefit, your group term life coverage will be reinstated at no further cost to you or the employer.

Your Extended Life Benefit With Waiver Of Premium (Cont.)

When This Extension Begins Once approved by us, your extended benefit will be effective on the later of:

- (a) 09 continuous months from the date active full-time service ends due to total disability; or
- (b) the date we approve you for this benefit.

CGP-3-R-LW-TD-99-1

B275.0535

When This Extension Ends Your extension will end on the earliest of:

- (a) the date you are no longer disabled;
- (b) the date we ask you to be examined by our doctor, and you refuse;
- (c) the date you do not give us the proof of disability we require;
- (d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or
- (e) the day before the date you reach age 65.

If the extension ends, and you are not insured by the group plan again as an active full-time employee, you can convert as if your employment just ended. Read the section labeled "Converting This Group Term Life Insurance".

If You Die While Covered By This Extension If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee. The benefit amount is also subject to reduction which applies at retirement. We will use your Social Security Normal Retirement Age, as defined in the 1983 amendment to the Social Security Act, to determine when to apply the retirement reduction to your extended life benefit.

Proof Of Death We'll pay as soon as we receive

- (a) written proof of your death, that is acceptable to us; and
- (b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

CGP-3-R-LW-TD-99-2

B275.0070

Your Dependent Spouse and Child Optional Term Life Insurance

The Benefit Subject to the limitations and exclusions shown below, if one of your dependents dies while insured for this benefit, we pay the amount shown in the schedule for the plan you have elected. We pay this in a lump sum when we receive written proof of death which is acceptable to us. Send the proof to us as soon as possible.

We pay you, if you're living. If you're not, and the dependent was your child, we pay your spouse. If your spouse is not living, we pay the child's living brothers and sisters in equal shares. If there are none, we pay the child's estate. If the dependent was your spouse, we pay your spouse's estate.

Your Dependent Spouse and Child Optional Term Life Insurance (Cont.)

- Suicide Exclusion** We pay no benefits if the dependent's death is due to suicide, if such death occurs within two years from the effective date of the dependent's optional term life insurance under this *plan*. Also, we pay no increased benefit amount if the dependent's death is due to suicide, if such death occurs within two years from the effective date of the increase.
- Seatbelt and Airbag Benefits** If a dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, we will increase the benefit amount by \$5,000.00. And if a dependent dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase the benefit amount by an additional \$2,500.00, for a total increase of \$7,500.00.
- Payment to a Minor or Incompetent** If the beneficiary is a minor or not competent, we have the right to pay in monthly installments. We would pay the person who cares for and supports the beneficiary. We completely discharge our liability for any amounts paid this way.

CGP-3-R-DOPT-96

B293.0323

Converting This Dependent Term Life Insurance

- If Your Group Life Insurance Ends or You Stop Being Eligible** Dependent term life insurance ends for all of your dependents when your group life insurance ends. Your insurance ends when: (a) your active full-time employment ends; (b) you stop being a member of a class of employees eligible for employee group life insurance; (c) your group life insurance is extended under the Extended Life Benefit provision; or (d) you die.
- Dependent term life insurance also ends when you stop being a member of a class of employees eligible for dependent term life insurance.
- If one of the above happens, each dependent who was insured may convert all or part of his insurance.
- If This Plan Ends or Life Insurance is Dropped** Dependent term life insurance also ends for all of your dependents when this plan ends. And it ends if either employee or dependent term life insurance is dropped from this plan for all employees or for your class.
- If one of the above happens, and your dependents have been insured by a Guardian group life plan for at least five years, they can convert. But we limit the amount each dependent can convert to the lesser of: (a) \$2,000.00; and (b) the amount of his insurance under this plan less any group life benefits he becomes eligible for in the 31 days after this insurance ends.
- If a Dependent Stops Being Eligible** A dependent's term life insurance ends when he stops being an eligible dependent. This happens to a child when he reaches the limiting age shown in the schedule or when he marries. And it happens to a spouse when a marriage ends in legal divorce or annulment. If a dependent stops being eligible, that dependent can convert all or part of his insurance.
- The Converted Policy** The dependent can convert to one of the individual life insurance policies we normally issue. That policy can't include disability benefits. And it can't be a term policy.

Converting This Dependent Term Life Insurance (Cont.)

The premium for the converted policy will be based on: (a) the dependent's risk and rate class under this plan; and (b) the dependent's age when the converted policy takes effect. The converted policy takes effect at the end of the period allowed for conversion.

Ask your employer or write to us for details.

How and When to Convert To get a converted policy, the dependent must apply to us in writing and pay the required premium. He has 31 days after his group insurance ends to do this. We won't ask for proof that he's insurable.

If the dependent is a minor or not competent, the person who cares for and supports the dependent may apply for him.

Death During the Conversion Period If a dependent dies in the 31 days allowed for conversion, we pay the amount he could have converted, as stated above. We do this whether or not he applied for conversion.

CGP-3-R-DEPL

B295.0009

Your Basic Accidental Death And Dismemberment Benefits

The Benefit We'll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 90 days of the date of the accident.

Covered Losses Benefits will be paid only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Loss	Benefit
Loss of Life	100% of Insurance Amount
Loss of a hand	50% of Insurance Amount
Loss of a foot	50% of Insurance Amount
Loss of sight in one eye	50% of Insurance Amount
Loss of thumb and index finger of same hand	25% of Insurance Amount

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident.

Loss of:

- (a) a hand or foot means it is completely cut off at or above the wrist or ankle.
- (b) sight means the total and permanent loss of sight.

Your Basic Accidental Death And Dismemberment Benefits (Cont.)

Payment Of Benefits For covered loss of life, we pay the beneficiary of your basic group term life insurance.

For all other covered losses, we pay you, if you are living. If not, we pay the beneficiary of your basic group term life insurance.

We pay all benefits in a lump sum, as soon as we receive proof of loss which is acceptable to us. This should be sent to us as soon as possible.

CGP-3-R-ADCL1-00

B310.0396

Exclusions We won't pay for any loss caused:

- by willful self-injury, suicide, or attempted suicide.
- by sickness, disease, mental infirmity, medical or surgical treatment.
- by your taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony.
- by travel on any type of aircraft if you are an instructor or crew member; or have any duties at all on that aircraft.
- by war or act of war, except loss of life which occurs while you are not actively serving in the military. War includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization. Act of war means any act peculiar to military, naval or air operations in time of war. Military includes persons serving on active, Reserve and Guard duty.
- while you are in the military. Military includes persons serving on active, Reserve and Guard duty.
- while you are a driver in a motor vehicle accident, if you do not hold a current and valid driver's license.
- by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle.
- by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

CGP-3-R-ADCL2-07

B310.0944

Your Voluntary Accidental Death And Dismemberment Benefits

The Choices You may elect to be insured for any of the plans of employee voluntary accidental death and dismemberment (ADD) insurance offered by the employer. These plans are shown in the schedule. However, you can only be insured under one plan at a time. You must notify the employer of your election and pay the required premium.

Your Voluntary Accidental Death And Dismemberment Benefits (Cont.)

You may switch to another plan of benefits at any time, subject to any of this plan's proof of insurability requirements. You must notify the employer of any desired switch.

The Benefit We'll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 90 days of the date of the accident.

Covered Losses Benefits will be paid according to the plan you have elected, only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Loss	Benefit
Loss of Life	100% of Insurance Amount
Loss of a hand	50% of Insurance Amount
Loss of a foot	50% of Insurance Amount
Loss of sight in one eye	50% of Insurance Amount
Loss of thumb and index finger of same hand	25% of Insurance Amount

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident.

Loss of:

- (a) a hand or foot means it is completely cut off at or above the wrist or ankle.
- (b) sight means the total and permanent loss of sight.

Payment Of Benefits For covered loss of life, we pay the beneficiary described below.

For all other covered losses, we pay you, if you are living. If not, we pay the beneficiary described below.

We pay all benefits in a lump sum, as soon as we receive proof of loss which is acceptable to us. This should be sent to us as soon as possible.

The Beneficiary You decide who gets this insurance if you die. You should have named a beneficiary on your enrollment form. You can change your beneficiary at any time by giving us notice, unless you have assigned insurance. But the change won't take effect until we give you confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, your insurance will be divided equally by the beneficiaries still alive, unless you tell us otherwise.

Your Voluntary Accidental Death And Dismemberment Benefits (Cont.)

If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.

CGP-3-R-ADCL1-00

B310.1424

Exclusions We won't pay for any loss caused:

- by willful self-injury, suicide, or attempted suicide.
- by sickness, disease, mental infirmity, medical or surgical treatment.
- by your taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony.
- by travel on any type of aircraft if you are an instructor or crew member; or have any duties at all on that aircraft.
- by war or act of war, except loss of life which occurs while you are not actively serving in the military. War includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization. Act of war means any act peculiar to military, naval or air operations in time of war. Military includes persons serving on active, Reserve and Guard duty.
- while you are in the military. Military includes persons serving on active, Reserve and Guard duty.
- while you are a driver in a motor vehicle accident, if you do not hold a current and valid driver's license.
- by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle.
- by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

CGP-3-R-ADCL2-07

B310.1485

ELIGIBILITY FOR DISABILITY COVERAGE

B329.0002-R

Employee Coverage

Eligible Employees To be eligible for employee coverage, you must be an active *full-time employee*. And you must belong to a class of *employees* covered by this *plan*.

Other Conditions You must:

- (a) be legally working in the United States.
- (b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 20 hours per week), at:
 - (i) your *employer's* place of business;
 - (ii) some place where your *employer's* business requires you to travel; or
 - (iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

Note: If you are working outside the United States on a temporary assignment and you meet all other conditions of eligibility, you will be covered by this *plan*, provided that: you are on an assignment, not exceeding one year, in a country or region that is not under a travel warning issued by the US Department of State. Coverage may be available when you are: (1) on a longer temporary assignment; or (2) assigned in a region that is under a travel warning; however, coverage must be approved by us in writing.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. Other parts of this coverage explain if and when we require *proof*. You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

CGP-3-EC-90-1.0

B329.0165-R

When Your Coverage Starts Employee benefits that don't require *proof* that you are insurable are scheduled to start on your effective date.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12:01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your occupation on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you are so capable and are working your regular number of hours.

Sometimes, your effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

CGP-3-EC-90-2.0

B264.3210-R

Delayed Effective Date For Disability Coverage

With respect to this *plan's* disability insurance, if an *employee* is not actively at work on a *full-time* basis on the date his or her coverage is scheduled to start, due to *sickness* or *injury*, we'll postpone coverage for an otherwise covered loss due to that condition. We'll postpone such coverage until he or she completes 10 consecutive days of active *full-time* service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date the *employee* returns to active *full-time* service.

CGP-3-DEF-97

B329.0103

When Your Coverage Ends

Your long term disability coverage ends on the date your active *full-time* service ends for any reason.

It also ends on the date you stop being a member of a class of *employees* eligible for insurance under this *plan*, or when this *plan* ends for all *employees*. And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

It ends on the date you are no longer working in the United States, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning issued by the US Department of State; or (2) for which we have agreed, in writing, to provide coverage.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

However, if you are disabled, as defined by this *plan* when your active *full-time* service ends, coverage remains in force during: (a) the elimination period, subject to premium payment, if (i) the disability is not excluded under the *plan*; and (ii) benefits are not excluded due to application of this *plan's* pre-existing condition provision; and (b) the period for which benefits are payable under this *plan*.

CGP-3-EC-90-3.0

B329.0175

Your Right To Continue Group Long Term Disability During A Family Leave Of Absence

Important Notice This section may not apply. You must contact your *employer* to find out if your *employer* must allow for a leave of absence under federal law. In that case the section applies.

Continuation of Long Term Disability Coverage Your long term disability coverage may be continued at your employer's option. You must contact your employer to find out if you may continue this coverage.

If Your Group Coverage Would End Group long term disability coverage may normally end for an *employee* because he or she ceases work due to an approved leave of absence. But, the *employee* may continue his or her group coverage if the leave of absence has been granted: (a) to allow the *employee* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the *employee's* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the *employee* is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The *employee* will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends Coverage may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan*.
- The end of the period for which the premium has been paid.

Definitions As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee*.
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0

B329.1110

LONG TERM DISABILITY HIGHLIGHTS

This page provides a quick guide to some of the plan features about which people most often want to know. But it's not a complete description of your long term disability plan. Read the following pages carefully for a complete explanation of what we pay, limit, and exclude.

CGP-3-LTD2K-HL B380.1513

Own Occupation Period The first 24 months of benefit payments from this plan.

CGP-3-LTD2K-HL B380.1578-R

Elimination Period For disability due to injury 90 days

For disability due to sickness 90 days

CGP-3-LTD2K-HL B380.1526

Maximum Payment Period See the following table:

For a disability starting before the *employee* reaches age 60, the *maximum payment period* will last until the Social Security Normal Retirement Age as shown in the following table:

Employee's Year of Birth	Social Security Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

For a disability starting on or after the employee reaches age 60, the maximum payment period will be determined according to the following table:

Age When Disability Starts	Maximum Payment Period
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years

Age 68 1.25 years
 Age 69 or older 1.00 year

But if an employee whose disability starts after age 60 reaches the end of the maximum payment from this table before he reaches the Social Security Normal Retirement Age, we will extend his maximum payment period until he reaches Social Security Normal Retirement Age.

CGP-3-LTD2K-HL B380.1529

Benefit Percent 55%

CGP-3-LTD2K-HL B380.1534

Maximum Monthly Benefit 55% of your *insured earnings*, rounded to the nearest \$1.00, if not already a multiple thereof, limited to a maximum of \$6,000.00.

NOTE: We integrate your *gross monthly benefit* with certain other income you may receive. Read all the terms of this *plan* to see what income we integrate with, and how.

CGP-3-LTD2K-HL B380.2600

Survivor Benefit 3 times the last monthly benefit after it is reduced for income earned during disability you received.

CGP-3-LTD2K-HL B380.0265

LONG TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income if you become disabled due to sickness or injury.

We decide: (a) if you are eligible for this insurance; (b) if you meet the requirements for benefits to be paid; and (c) what benefits are to be paid by this plan. We also interpret how this plan is to be administered. What we pay and the terms for payment are explained below.

All terms in *italics* are defined terms with special meanings. Their definitions are shown at the end of this section. Other terms are defined where they are used.

Claim Provisions

- Your Duties** If you become *disabled* due to *sickness* or *injury* while insured by this *plan*, you must:
- (a) Give notice of claim as soon as possible after the date of your *injury* or the start of your *sickness*. Prompt notice will permit us to start case management. See the "Rehabilitation and Case Management" section of this *plan* for details.
 - (b) Give a complete account of the details of your *sickness* or *injury*. This will include: (i) the cause of your *disability*, if known; (ii) a description of your *sickness* or the accident that caused your *injury*; and (iii) a list of all *doctors*, hospitals, or other facilities where you have been treated for the cause of your *disability*.
 - (c) Allow release of medical and/or income data needed to assess your claim.
 - (d) Give periodic medical updates as required by this *plan*.
 - (e) Take part in any medical, financial or vocational assessment as required by this *plan*.
 - (f) Apply for other income benefits to which you may be entitled.
 - (g) Promptly report to us the receipt or denial of such other income benefits. And, appeal any denials to the extent possible.
 - (h) Promptly report to us changes in your personal status. This includes: (i) change of address or phone number; (ii) changes in how your *disability* affects your daily living; and (iii) changes in your level of social, volunteer or business activities.
 - (i) If we overpay benefits, promptly report and repay any amount overpaid.
 - (j) If you are working while *disabled*, promptly report to us the amount of your income from such work.
 - (k) Give us proof of your earnings for the period prior to your *disability* and while you are *disabled*.

Notice You must send us written notice of your intent to file a claim under this *plan* as described in this certificate's "Accident and Health Claims Provisions." Notice must include:

Claim Provisions (Cont.)

- (a) your full name; phone number; social security number, and group number;
- (b) the date of your last day worked; the number of hours you worked; and your job title;
- (c) your *employer* contact and phone number;
- (d) a statement of the nature of your *disability*; and whether or not it is work-related;
- (e) your *doctor's* name, address and phone number.

For details, you can call Guardian at 1-800-538-4583.

Proof Of Loss When we receive your notice, we will provide you with a claim form for filing proof of loss. This form requires data from you, the *plan sponsor*, and the *doctor(s)* treating you for your *sickness* or *injury*. Proof of loss must be given to us within the time stated in this certificate's "Accident and Health Claims Provisions." If you do not receive a claim form within 15 days of the date you sent your notice, you should send us written proof of loss without waiting for the form.

We require the items listed below as proof of loss:

- (a) During the *elimination period* and the *own occupation* period, medical evidence in support of the limits on your ability to perform your *own occupation*, starting on the date you first became *disabled*. This proof is required from all *doctors* who have treated you for the cause of your *disability*.

After the *own occupation* period, medical evidence in support of the limits on your ability to perform any *gainful work*.

- (b) Proof that you have applied for all other sources of income to which you may be entitled, that may affect your payment from this *plan*.
- (c) Proof of receipt of other income that may affect your payment from this *plan*.
- (d) Your signed authorization for release of medical and/or financial data by the sources of such data.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Long Term Disability Claims Department
P.O. Box 14331
Lexington, KY 40512

CGP-3-LTD2K01-1.0

B380.3702

To Qualify For Payments

How Payments Start To start getting payments from this *plan*, you must meet all of the conditions listed below:

To Qualify For Payments (Cont.)

- (a) You must: (i) become *disabled* while insured by this *plan*; and (ii) remain *disabled* and insured for this *plan's elimination period*.
- (b) You must be: (i) under a *doctor's regular care* for the cause of your *disability*, starting from the date you were first *disabled*; and (ii) receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability*.
- (c) You must send us written documentation of: (i) medical evidence in support of the limits causing your *disability*; (ii) your monthly earnings prior to the start of your *disability*; and (iii) any earnings from work while you are *disabled*.

Proof of earnings may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

Waiver Of Premium Premiums for this insurance are waived while you are entitled to receive a payment from this *plan*.

To Continue Receiving Payments To continue to receive payments from this *plan*, you must give us current proof of loss when we request it.

You must give proof that satisfies us as to the items listed below:

- (a) medical evidence in support of the limits causing your continued *disability*;
- (b) continued *regular care* by a *doctor* that is appropriate for the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability*;
- (c) earnings from work while you are *disabled*; and
- (d) any other income that you are entitled to receive.

You must also give us current signed authorizations for release of medical and financial data when we request it.

You must permit such assessments and give us such items within 90 days of the date we make each such request. If you do not, we have the right to suspend or stop your payments under this *plan*.

Right To Request Medical Financial Or Vocational Assessment We may ask you to take part in a medical, financial or vocational assessment as often as we feel is reasonably necessary. We will pay for all such assessments. If you do not take part in the assessment, we have the right to stop or suspend your payments under this *plan*.

CGP-3-LTD2K01-2.0

B380.0429

Payment Of Benefits We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.

To Qualify For Payments (Cont.)

We pay benefits once each month at the end of the period for which they are payable.

Benefits to which you are entitled may remain unpaid at your death. Such benefits may be paid at our discretion to: (a) your estate; or (b) your spouse, parents, children, or brothers and sisters.

CGP-3-LTD2K-2.1

B380.0015

When Benefits End

When Payments End Your benefits from this *plan* will end on the earliest of the dates shown below:

- (a) The date you are no longer *disabled*.
- (b) The date you earn, or are able to earn, the maximum earnings allowed while *disabled* under this *plan*.
- (c) The date you are able to perform the major duties of your *own occupation* on a full-time basis with reasonable accommodation that an employer is willing to provide.
- (d) After the *own occupation* period, the date you are able to perform the major duties of any *gainful work* on a full-time basis with reasonable accommodation that an employer is willing to provide.
- (e) The date you no longer reside in the United States.
- (f) The date you die.
- (g) The end of the *maximum payment period*.
- (h) The date you fail to give us required current proof of loss. This includes taking part in any medical, financial or vocational assessment we may require.
- (i) The date you are no longer under the *regular care* of a *doctor*.
- (j) The date payments end in accord with a *rehabilitation agreement*.
- (k) The date you refuse to take part in a *rehabilitation program*.

The term "reasonable accommodation" means any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place. The modification or adjustment must make it possible for a *disabled* person to: (1) reach the same level of performance as a similarly situated non-disabled person; or (2) enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person. The modification or adjustment must not place an undue hardship on the employer.

CGP-3-LTD2K-3.0

B380.0019

When Benefits End (Cont.)

Maximum Payment Period The *maximum payment period* is the longest time that benefits are paid by this *plan* for your *disability*. It is determined by the table shown below.

But, it may be less than that shown due to the nature of your *disability*. See "Special Limitations."

For a disability starting before the *employee* reaches age 60, the *maximum payment period* will last until the Social Security Normal Retirement Age as shown in the following table:

Employee's Year of Birth	Social Security Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

For a disability starting on or after the employee reaches age 60, the maximum payment period will be determined according to the following table:

Age When Disability Starts	Maximum Payment Period
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

But if an employee whose disability starts after age 60 reaches the end of the maximum payment from this table before he reaches the Social Security Normal Retirement Age, we will extend his maximum payment period until he reaches Social Security Normal Retirement Age.

CGP-3-LTD2K-3.1

B380.2060-R

Special Limitations We limit the *maximum payment period*, if you are *disabled* due to a condition listed below.

The *maximum payment period* for all such periods of *disability* is 24 months. This is a combined maximum for all such conditions and all periods of *disability*.

We limit the *maximum payment period* for *disabilities* caused or contributed to by the following conditions:

When Benefits End (Cont.)

- *Mental or emotional conditions*
- Drug or alcohol abuse

This limitation will not apply to *disabilities* caused or contributed to by the following conditions:

- Schizophrenia
- Dementia
- Organic brain syndromes
- Amnesia syndromes
- Organic delusional or hallucinogenic syndromes

No benefits will be paid for *disability* due to a *mental or emotional condition* or drug or alcohol abuse if you are not receiving treatment for the cause of the *disability* from a provider, or in a facility that is: (a) licensed by the state to provide treatment for such condition; and (b) accredited or approved by the Joint Commission on the Accreditation of Health Care Facilities or Medicare.

If payments under this *plan* would end due to the limits in this section, we may extend such payments, as shown below. But, you must meet all of the following conditions: (a) you must be *disabled* due to a condition named above; (b) you must be an inpatient in a qualified institution because of your *disability*; and (c) you must have been treated as an inpatient for at least 14 days in a row. In such case, we extend payments until the earliest of: (i) 90 days from the date of your discharge; (ii) the end of this *plan's maximum payment period*; or (iii) the date your *disability* ends.

The term "qualified institution" means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your *disability*.

If This Plan Ends This insurance ends when the group plan ends. It also ends when this insurance is dropped from the group plan for all insureds, or for your class. If you are *disabled* when this insurance ends, we will treat you as if your insurance did not end. But, your benefit will be based on all of the terms of this *plan*.

CGP-3-LTD2K01-3.2

B380.1224

To Determine Your Benefit

Your benefit is determined by the plan of benefits and your *insured earnings* in effect on the date your *disability* starts.

Any changes to this *plan* that take place while you are *disabled* will not affect how we determine your benefit. This is also true for any changes that take place during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability*.

To Determine Your Benefit (Cont.)

Determining Your Monthly Benefit

Your *monthly benefit* is determined as shown below.

- (a) Multiply your *insured earnings* by 55%. Round this amount to the nearest dollar.
- (b) If the amount determined above is less than this *plan's maximum monthly benefit*, that amount is your *gross monthly benefit*.

If the amount determined above is equal to or more than this *plan's maximum monthly benefit*, your *gross monthly benefit* is equal to the *maximum monthly benefit*.
- (c) From your *gross monthly benefit*, subtract the amount of any income listed in "Income We Integrate With" that you receive or are entitled to receive. The result is your *monthly benefit*.

The amount of your *gross monthly benefit* may be limited if:

- (a) you have not provided any proof of insurability required by this *plan*;
- (b) we have not given you written approval of such proof; or
- (c) the *plan sponsor* has not updated the amount of your *insured earnings* to reflect your then current *insured earnings* on the most recent reporting date prior to the start of your *disability*.

See the "Redetermination" and "Proof of Insurability" section of this *plan* for details.

CGP-3-LTD2K-4.0

B380.1956-R

Redetermination

This plan redetermines *insured earnings* for each covered person on December 1st. Each December 1st, the *plan sponsor* must report current *insured earnings* for all covered persons under the *plan*. Changes to a covered person's *insured earnings* are subject to any proof of insurability requirements of this *plan*. As of this *plan's* redetermination date, we use a covered person's *insured earnings* on record with us to: (a) set rates; (b) project benefit amounts and limits; and (c) calculate premium payable under this *plan*. However, the covered person must be *actively-at-work* on a full-time basis on that date. If he or she is not, we do not do this until the date he or she returns to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability*.

CGP-3-LTD2K01-4.2

B380.0437

Income We Integrate With

You may receive, or be entitled to receive, income shown in the list below. We will integrate your *gross monthly benefit* with such income to determine your *monthly benefit* from this *plan*.

- Commissions received, due to be received, or paid after *disability* benefits start. This includes vested and nonvested renewal commissions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.

To Determine Your Benefit (Cont.)

- Disability benefits from all group plans of: (1) the *plan sponsor*; or (2) your *employer*. This includes payments made by a group life insurance plan due to your *disability*. This does not include payments made from a group life insurance plan's: (a) accelerated death benefit; or (b) like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group plan.
- Income from a sick leave or salary continuance plan. This applies whether such plan is sponsored on a formal or informal basis. This includes lump sum or recurrent payments of accrued sick leave benefits.
- Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.
 - (a) All disability benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your *disability*;
 - (b) All unreduced retirement benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your qualification; and
 - (c) all reduced retirement benefits paid to: (i) you; and (ii) your spouse and children due to your receipt of such benefits.

We will integrate your *gross monthly benefit* with such benefits to which your spouse and children are entitled due to your receipt of, or qualification for, disability benefits. We do this without regard to: (a) your marital status; (b) where you live; (c) where your spouse lives; (d) where your child lives; or (e) any custody arrangements made on behalf of your child.

- *Retirement plan retirement benefits* funded for your benefit by: (1) the *plan sponsor*; or (2) your *employer*.
- *Retirement plan disability benefits*.
- *Retirement benefits* or *retirement plan disability benefits*, due to your *disability*, from any *government plan* other than those shown above.
- Benefits from: (1) a Workers' Compensation law; (2) an occupational disease law; or (3) any other act or law of like intent. This includes: (a) the Jones' Act; (b) the Longshoreman's and Harbor Workers' Compensation Act; or (c) any Maritime doctrine of Maintenance, Wages or Cure.
- Disability benefits from any third party when your *disability* is the result of the negligence or intentional tort liability of that third party.
- Payment from your *employer* as part of a termination agreement.

We integrate your *gross monthly benefit* with income shown above that you are entitled to receive without regard to the reason you are entitled to receive it.

To Determine Your Benefit (Cont.)

Our right to reduce your benefit by such income shall not be negated by a transfer of claim liability to a third party. Payment by such third party by law, settlement, judgement, waiver or otherwise shall not negate our right.

CGP-3-LTD2K-4.3

B380.0545

Lump Sum Payments Of Other Income Income with which we integrate may be paid in a lump sum. In this case, we take the equivalent monthly rate stated in the award into account when we determine your *monthly benefit*. If no monthly rate is given, we pro-rate the lump sum over the lesser of: (a) 60 months; or (b) the *maximum payment period*.

Cost Of Living Freeze You may receive a cost of living increase in other income with which we integrate. In this case, we do not further reduce your *monthly benefit* by the amount of such increase.

Application For Other Income You must apply for other income benefits to which you may be entitled. If these benefits are denied, you must appeal until: (a) all possible appeals have been made; or (b) we notify you that no further appeals are required.

If we feel you are entitled to receive such income benefits, we will estimate the amount due to you and your spouse and children. We will take this estimated amount into account when we determine your *monthly benefit*. But, we will not take this estimated amount into account if you sign our reimbursement agreement. In this agreement you promise: (a) to apply for any benefits for which you may be eligible; (b) to appeal any denial of such benefits until all possible appeals have been made; and (c) to repay any amount we overpaid due to an award of such benefits.

If we do reduce your *gross monthly benefit* by an estimated amount, we will adjust your *monthly benefit* when we receive written proof: (a) of the amount awarded; or (b) that the other income benefits have been denied; and no further appeals are possible. If we underpaid you, we pay the full amount of the underpayment in a lump sum.

We will assist you in applying for other income benefits.

CGP-3-LTD2K-4.4

B380.0062

Minimum Payment The minimum monthly payment for *disability* under this *plan* is \$100.00.

Partial Month Payment You may be *disabled* for only part of a month. In this case, we compute your payment as 1/30th of the benefit to which you would be entitled for the full month times the number of days you are *disabled*. Payment will not be made for more than 30 days in any month.

Overpayment Recovery If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

CGP-3-LTD2K-4.5

B380.0064

If You Work While Disabled

Income Earned During Disability Subject to the other terms of this *plan*, if you are working to your *maximum capacity*, income earned during disability is treated as shown below while this *plan* pays benefits. In all cases, your *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

1. For each of the first 12 months after you return to work, add your *gross monthly benefit* and your *income earned during disability*.
 - (a) If the sum is not more than 100% of your *insured earnings*, we do not reduce your *monthly benefit* for that month.
 - (b) If the sum is more than 100% of your *insured earnings*, we reduce your *monthly benefit* for that month by the amount over 100% of your *insured earnings*.
2. For each month after 12 months of work while *disabled*:
 - (a) If your *income earned during disability* is less than 20% of your *insured earnings*, we do not reduce your *monthly benefit* for that month.
 - (b) If your *income earned during disability* is 20% or more of your *insured earnings*, we reduce your *monthly benefit* for that month by 50% of your *income earned during disability*.

CGP-3-LTD2K01-5.0

B380.0442

Part-Time Earnings Capacity If you are able to work *part-time* while *disabled*, but you are not working to your *maximum capacity*, we adjust the *monthly benefit* as follows.

During the *own occupation* period, we reduce your *monthly benefit* by 50% of the income you would currently be able to earn, if working to your *maximum capacity*, in your *own occupation*. After the *own occupation* period, we reduce your *monthly benefit* by 50% of the income you would currently be able to earn, if working to your *maximum capacity*, in any *gainful occupation*.

Maximum Income Earned During Disability This *plan* limits the amount of income you may earn, or may be able to earn, and still be considered *disabled*.

If your *income earned during disability* is more than 80% of your *insured earnings*, payments from this *plan* will end. Payments from this *plan* will also end if you are able to earn more than 80% of your *insured earnings*.

In all cases, your *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

CGP-3-LTD2K01-5.1

B380.0519

Indexing If you return to work while *disabled*, we adjust your *insured earnings* each year. We do this by means of an indexing factor. This factor increases the amount of income you may earn and still be considered *disabled*. This adjustment does not increase your *gross monthly benefit*, *monthly benefit*, or any other benefit under this *plan*.

We make the first indexing adjustment after you: (a) have returned to work; and (b) have received 12 monthly payments in a row from this *plan*.

If You Work While Disabled (Cont.)

To make the first adjustment, we multiply your *insured earnings* by the indexing factor for that year. To make adjustments in each later year, we multiply the amount of your last indexed *insured earnings* by the indexing factor for the current year.

The indexing factor is the lesser of: (a) 10%; or (b) one-half of the percentage change in the *CPI-W* for the prior calendar year.

CGP-3-LTD2K-5.2

B380.0073

Recurring Disability

Your benefits from this *plan* will end because you cease to be *disabled*. In this case, a later *disability* may be treated as a *recurring disability*. The terms listed below must be met:

- (a) You return to *active work* right after your benefits end;
- (b) Your *disability* recurs less than six months after you were last entitled to benefits;
- (c) Your later *disability* is due to the same cause of, or a cause related to the cause of, your earlier *disability*;
- (d) This *plan* does not end during your return to *active work*;
- (e) You do not become covered under any other similar group income replacement plan during the time you return to *active work*; and
- (f) During the time you return to *active work*, you stay insured by this *plan* and premium payments are made on your behalf.
- (g) Your benefits do not end because you have used up the *maximum payment period*.

Any changes in benefit or the *plan* which take place during your return to *active work*, will not apply to the *recurring disability*.

If the later *disability* is a *recurring disability*, you will not need to complete a new *elimination period* before becoming entitled to benefits. Your claim for *recurring disability* will be subject to the same terms of the *plan* as your earlier *disability*.

CGP-3-LTD2K-6.0

B380.0075

The Survivor Benefit

We may pay a survivor benefit if you die after you: (a) had been *disabled* for at least six months in a row; and (b) were entitled to receive at least one full *monthly benefit*. When we receive proof of your death, we pay your eligible survivor a lump sum benefit.

We pay a benefit equal to 3 times the amount of your last *monthly benefit* after it is reduced by *income earned during disability*. But, we first apply such benefit to reduce any overpayment you may owe us.

If you have no eligible survivor, no survivor benefit is paid.

Additional Benefits (Cont.)

Your eligible survivor is your spouse, if living.

If your spouse is not living, your eligible survivor is your: (a) unmarried child under age 20; and (b) unmarried child under age 26 who is enrolled as a full-time student at an accredited school. If there is more than one such child when you die, this benefit will be paid to each child in equal shares.

CGP-3-LTD2K-7.1

B380.0081

Services Available

Social Security Assistance We may feel you are qualified for Social Security disability benefits. If so, we may offer to help you apply for them. If such benefits are under review by Social Security, we may also offer to help you keep them.

We may offer to help:

- (a) Fill out your application for such benefits, and any related forms;
- (b) Find suitable legal counsel; and
- (c) Give medical and vocational data needed to file your claim.

You must apply for all income benefits for which you may be eligible, whether or not you use our help. Using our help does not cancel your duties shown in the "Application for Other Income" section of this *plan*.

Rehabilitation And Case Management

Case management starts when we are notified of your *disability*.

We will review your *disability* to see if certain services are likely to help you return to *gainful work*. If needed, we may ask for more medical or vocational information.

When our review is complete, we may offer you a *rehabilitation program*. We have the right to suspend or end your *monthly benefit* if you do not accept it.

The *rehabilitation program* will start when a written *rehabilitation agreement* is signed by: (1) you; (2) us; and (3) your *employer*, if needed. The program may include, but is not limited to:

- (a) vocational assessment of your work potential;
- (b) coordination and transition planning with an employer for your return to work;
- (c) consulting with your *doctor* on your return to work and need for accommodations;
- (d) training in job seeking skills and resume preparation;
- (e) retraining;
- (f) child care expense aid; and
- (g) aid in worksite alteration made to comply with the Americans with Disabilities Act. This includes a one-time payment of up to \$2,500.00.

We have the right to determine which services are appropriate.

Services Available (Cont.)

If you accept the *rehabilitation agreement*, we will pay an enhanced benefit. The enhanced benefit will be 110% of the *monthly benefit* that would otherwise be paid. This enhanced benefit will be payable as of the first *monthly benefit* after the *rehabilitation program* starts.

We stop paying the enhanced benefit on the earliest of:

- (a) The date your benefits from this *plan* end,
- (b) The date you violate the terms of the *rehabilitation agreement*;
- (c) The date you end the *rehabilitation program*; and
- (d) The date the *rehabilitation agreement* ends.

If you end a *rehabilitation program* without our consent, you must repay any enhanced benefits paid.

CGP-3-LTD2K-8.0

B380.0089

Pre-Existing Conditions

Pre-Existing Conditions A pre-existing condition is a *sickness* or *injury*, including all related conditions and complications, for which, in the look back period, you:

- (a) receive advice or treatment from a *doctor*;
- (b) take prescribed drugs; or
- (c) receive other medical care or treatment, including consultation with a *doctor*.

You may have been prescribed drugs by a *doctor* for a condition to be taken during the look back period. In that case, such condition or a related condition will be considered pre-existing.

The "look back period" is the three months before the latest of: (a) the effective date of your insurance under this *plan*; (b) the effective date of a change that increases the benefits payable by this *plan*; and (c) the effective date of a change in your benefit election that increases the benefit payable by this *plan*.

A pregnancy that exists on the date your insurance under this *plan* starts is also a pre-existing condition.

No benefits are payable for *disability* due to a pre-existing condition, unless the *disability* starts after you complete at least one full day of *active work* after the date you are insured under this *plan* for 12 months in a row.

You may become *disabled* due to a pre-existing condition after: (a) a change which provides for an increase in the benefits payable by this *plan*; or (b) a change in your benefit election which increases the benefit payable by this *plan*. In this case, your benefit will be limited to the amount that would have been payable had the change not taken place. This limit does not apply if your *disability* starts after you complete at least one full day of *active work* after the change has been in force for 12 months in a row.

Pre-Existing Conditions (Cont.)

We do not cover any *disability* that starts before your insurance under this *plan*.

CGP-3-LTD2K-9.0

B380.0090

Prior Coverage Credit If this *plan* replaces a similar income replacement plan the *plan sponsor* had with another insurer, the pre-existing condition provision may not apply to you. This *plan* must start right after the old plan ends.

We credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision. If the old plan did not have a pre-existing condition provision, we credit any time you were covered under the old plan toward meeting this *plan's* pre-existing condition provision. We do this if: (a) you were covered under the old plan when it ended; and (b) you are *actively-at-work* and enroll for insurance on the effective date of this *plan*.

But, we limit the *maximum monthly benefit* under this *plan* if: (a) it is more than the old plan's maximum; (b) you become *disabled* due to a pre-existing condition; and (c) this *plan* pays benefits for such *disability* because we credit time as explained above. In this case, we limit the *maximum monthly benefit* to an amount equal to the old plan's maximum.

We deduct all payments made by the old plan under an extension provision.

CGP-3-LTD2K-9.1

B380.0092

Not Covered

Exclusions This *plan* does not pay benefits for *disability* caused by, or related to:

- (a) declared or undeclared war, act of war, or armed aggression;
- (b) service in the armed forces, National Guard, or military reserves of any state or country;
- (c) your taking part in a riot or civil disorder;
- (d) your commission of, or attempt to commit a crime; or
- (e) intentional self-inflicted injuries.

We do not pay any benefits for any period of *disability*:

- (1) during which you are confined to a facility as a result of your conviction of a crime;
- (2) during which you are not receiving regular care by a *doctor*;
- (3) during which you are not receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability*;
- (4) which starts before you are insured by this *plan*; or
- (5) during which your loss of earnings is not solely due to your *disability*.

CGP-3-LTD2K-10.0

B380.0093

Definitions

Active Work, Actively-At-Work Or Actively Working You are able to perform and are performing all of the regular duties of your work for your *employer*, on a full-time basis at: (a) one of your *employer's* usual places of business; (b) some place where your *employer's* business requires you to travel; or (c) any other place you and your *employer* have agreed on for your work.

CGP-3-LTD2K-12.0

B380.0098

CPI-W That part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. The change in cost is expressed as a percentage of the cost of those goods and services in a base period. When we compute the change in *CPI-W*, we use the value of the *CPI-W* published in December of that year and the value published in December of the prior year. If the Department of Labor stops publishing the *CPI-W*, we have the right to use some other similar standard.

CGP-3-LTD2K-12.2

B380.0100

Disability Or Disabled These terms mean you have physical, mental or emotional limits caused by a current *sickness* or *injury*. And, due to these limits, you are not able to perform the major duties of your *own occupation* or any *gainful work* as shown below:

- (1) During the *elimination period* and the *own occupation* period, you are not able to perform, on a full-time basis, the major duties of your *own occupation*.
- (2) After the end of the *own occupation* period, you are not able to perform, on a full-time basis, the major duties of any *gainful work*.

You are not *disabled* if you earn, or are able to earn, more than this *plan's* maximum allowed *income earned during disability*.

You may be required, on average, to work more than 40 hours per week. In this case, you are not *disabled* if you are able to work for 40 hours per week.

Loss of a professional or occupational license will not, in itself, constitute *disability*.

CGP-3-LTD2K-12.3

B380.0102

Doctor Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice. We do not recognize you, or your spouse, child, parent, sibling, or business associate, as a *doctor* with respect to your claim for this *plan's* benefits.

Elimination Period The period of time you must be *disabled*, due to a covered *disability*, before this *plan's* benefits are payable.

Any days during which you return to *active work* will not count toward the *elimination period*. The *elimination period* will be extended by one day for each day of *active work*. If you become eligible under any other similar group income replacement plan while you are at *active work*, you will not be entitled to benefits from this *plan*.

Definitions (Cont.)

Employer	The business entity that employs you and is: (a) the <i>plan sponsor</i> ; or (b) associated with the <i>plan sponsor</i> .	
	CGP-3-LTD2K-12.10	B380.0112
Gainful Occupation or Gainful Work	Work for which you are, or may become, qualified by: (a) training; (b) education; or (c) experience. When you are able to perform such work on a full-time basis, you can be expected to earn at least 80% of your indexed <i>insured earnings</i> , within 12 months of returning to work.	
Government Plan	Any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee retirement plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers' Compensation Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.	
Gross Monthly Benefit	This <i>plan's monthly benefit</i> before it is reduced by other income and earnings.	
Income Earned During Disability	The monthly income you earn from working while <i>disabled</i> . It includes any income you earn while <i>disabled</i> but which is returned to your <i>employer</i> , partnership, or any other similar business arrangement to cover any business or overhead expenses.	
Injury	A bodily <i>injury</i> due to an accident that occurs, independent of all other causes, while you are insured by this <i>plan</i> . We will cover a <i>disability</i> caused by an <i>injury</i> when the <i>disability</i> starts within 90 days of the date of such <i>injury</i> .	
	CGP-3-LTD2K01-12.11	B380.0458
Insured Earnings	Only your earnings from the <i>employer</i> will be included as <i>insured earnings</i> . We calculate benefit amounts and limits based on the amount of your <i>insured earnings</i> on record with us as of the Redetermination date immediately prior to the start of your <i>disability</i> . See the "Redetermination" section of this <i>plan</i> . <i>Insured earnings</i> includes your contributions deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457. Earnings based on excluded income and <i>employer</i> contributions deposited into such 401(k), 403(b) or 457 plan are excluded. For all covered persons, <i>insured earnings</i> means your rate of monthly earnings, excluding bonuses, commissions, expense accounts, and any other extra compensation, as reported by the <i>plan sponsor</i> . If you are paid hourly, we calculate monthly earnings based on actual hours worked or billed in the two months before the start of your <i>disability</i> . We do not include pay for hours worked or billed over 40 per week. Such earnings are multiplied by 4.333.	
	CGP-3-LTD2K01-12.12	B380.0466

Definitions (Cont.)

Maximum Capacity	During the <i>own occupation</i> period, the fullest extent of work you are able to do in your <i>own occupation</i> . After the <i>own occupation</i> period, the fullest extent of work you are able to do in any <i>gainful occupation</i> . We decide the fullest extent of work you are able to do based on objective data provided by: (a) your treating <i>doctor</i> ; (b) impartial medical or vocational exams; (c) peer review specialists; (d) functional capacities exams; and (e) other medical and vocational specialists whose area of expertise is appropriate to your <i>disability</i> .
Maximum Payment Period	The longest time that benefits are paid by this <i>plan</i> .
Mental Or Emotional Conditions	Include, but are not limited to: (a) neurosis; (b) psychoneurosis; (c) psychosis; (d) psychopathy; and (e) any other mental or emotional disorder.
Monthly Benefit	This <i>plan's gross monthly benefit</i> reduced by other income. If you are working while <i>disabled</i> , your <i>monthly benefit</i> will be further reduced based on the amount of your <i>income earned during disability</i> . See the "If You Work While Disabled" provision of this <i>plan</i> for how this is done.
	CGP-3-LTD2K01-12.13 B380.0489
Own Occupation	Your occupation as done in the general labor market in the national economy. To determine the duties and requirements of your <i>own occupation</i> , we use: (a) the job description provided by the <i>plan sponsor</i> ; and (b) the duties and requirements of that occupation as shown in the most recent version of the Dictionary of Occupational Titles. That document is published by the Department of Labor. If the Department stops publishing that document, we have the right to use some other similar standard.
Part-Time	The ability to work and earn between 40% and 80% of <i>insured earnings</i> .
Plan Sponsor	The employer, association, union, trustee, or other group to which this <i>plan</i> is issued.
Recurring Disability	A later <i>disability</i> that: (a) is related to an earlier <i>disability</i> for which this <i>plan</i> paid benefits; and (b) meets the conditions described in "Recurring Disability."
Regular Care	A person is being treated by, or in consultation with, a <i>doctor</i> at a frequency that is consistent with his or her condition. The requirement for <i>regular care</i> does not apply if he or she has reached his or her maximum point of recovery yet is still disabled under the terms of this <i>plan</i> .
	CGP-3-LTD2K01-12.14 B380.0525
Rehabilitation Agreement	A formal agreement between; (a) you; (b) us; and (c) your <i>employer</i> , if needed. It outlines the <i>rehabilitation program</i> in which you agree to take part.
Rehabilitation Program	A program of work or job-related training for you that we approve in writing. Its aim is to restore your wage earning abilities.
Retirement Plan	A defined benefit or defined contribution plan funded wholly or in part by the <i>employer's</i> deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.

Definitions (Cont.)

Retirement Plan "**retirement benefits**" are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits*. When such payments do not reduce the normal retirement amount, they are "**disability benefits.**"

Sickness An illness or disease. Pregnancy is treated as a *sickness* under this *plan*.

We, Us, And Guardian The Guardian Life Insurance Company of America.

You The person insured by this *plan*.

CGP-3-LTD2K-12.15

B380.0135

GLOSSARY

	This Glossary defines the italicized terms appearing in your booklet.	
	CGP-3-GLOSS-90	B900.0118
Eligibility Date	for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.	
	CGP-3-GLOSS-90	B900.0003
Eligible Dependent	is defined in the provision entitled "Dependent Coverage."	
	CGP-3-GLOSS-90	B750.0015
Employee	means a person who works for the <i>employer</i> at the <i>employer's</i> place of business, and whose income is reported for tax purposes using a W-2 form.	
	CGP-3-GLOSS-90	B750.0006
Employer	means TOWN OF CONCORD .	
	CGP-3-GLOSS-90	B900.0051
Enrollment Period	with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.	
	CGP-3-GLOSS-90	B900.0004
Full-time	means the <i>employee</i> regularly works at least the number of hours in the normal work week set by the <i>employer</i> (but not less than 18.75 hours per week), at his <i>employer's</i> place of business.	
	CGP-3-GLOSS.1	B750.0230-R
Initial Dependents	means those <i>eligible dependents</i> you have at the time you first become eligible for <i>employee</i> coverage. If at this time you do not have any <i>eligible dependents</i> , but you later acquire them, the first <i>eligible dependents</i> you acquire are your <i>initial dependents</i> .	
	CGP-3-GLOSS-90	B900.0006
Newly Acquired Dependent	means an <i>eligible dependent</i> you acquire after you already have coverage in force for <i>initial dependents</i> .	
	CGP-3-GLOSS-90	B900.0008
Plan	means the <i>Guardian</i> group <i>plan</i> purchased by your <i>employer</i> , except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.	
	CGP-3-GLOSS-90	B900.0039
Proof or Proof of Insurability	means an application for insurance showing that a person is insurable.	
	CGP-3-GLOSS-90	B900.0010
Qualified Retirees	means an employee who: (a) has worked at least 10 years for the employer; and (b) retires at age 55 or older.	
	CGP-3-GLOSS-90	B750.0008-R

The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group term life insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Life Insurance Claims Procedure If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions "Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination of Life Insurance Claims The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

**Adverse Benefit
Determination of
Life Insurance
Claims**

If a claim is denied, Guardian will provide notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures; and
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination.

B752.0186

**Appeals of Adverse
Determinations of
Life Insurance
Claims**

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits; and
- Provide a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain information about such procedures, and a statement that the claimant's right to bring an action under ERISA section 502(a).

Waiver of Premium If you apply for an extension of life insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium The benefit determination period begins when claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the time period shown below. A written or electronic notification of any adverse determination must be provided.

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0365

Appeals of Adverse Determinations for Waiver of Premium If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and

- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0366

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group term accidental death and dismemberment insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Accidental Death and Dismemberment Insurance Claims Procedure If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions "Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

**Timing for Initial
Benefit
Determination of
Accidental Death
and
Dismemberment
Insurance Claims**

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

**Adverse Benefit
Determination of
Accidental Death
and
Dismemberment
Insurance Claims**

If a claim is denied, Guardian will provide notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement, that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B752.0200

**Appeals of Adverse
Determinations of
Accidental Death
and
Dismemberment
Insurance Claims**

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Waiver of Premium If you apply for an extension of accidental death and dismemberment insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the time period shown below. A written or electronic notification of any adverse determination must be provided.

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0368

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and the State insurance regulatory agency.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0369

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group Short Term and/or Long Term Disability Income benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

**Receive Information
about Your Plan and
Benefits**

- (a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

**Prudent Actions by
Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforcement of
Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Disability Benefits Claims Procedure If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions "Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

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**Adverse Benefit
Determination**

If a claim is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;

- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, and;
- In the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0371

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com



**The Guardian Life Insurance
Company of America**
10 Hudson Yards
New York, New York 10001

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