AMERICAN LIBRARY ASSOCIATION
ALL OTHER ELIGIBLE EMPLOYEE
Group Number: 00543094

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coverage on your feet.

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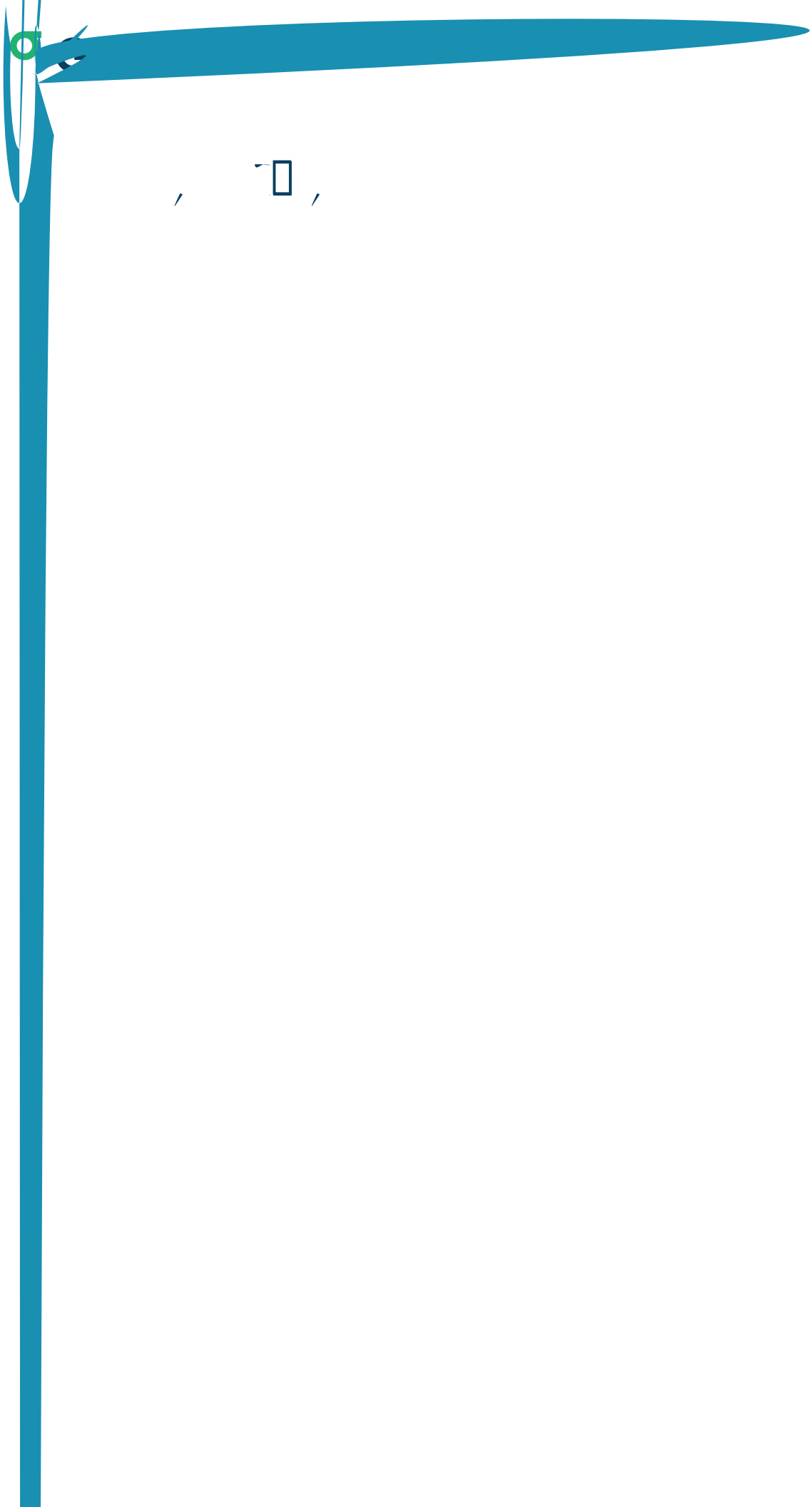

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Guardian®

Guardian

Hospital Indemnity

Option 1

Coverage Details

Benefits

Hospital/ICU Admission	$1,000 per admission, limited to 1 admission(s) per insured and 3 admission(s) per covered family per benefit year.
Hospital/ICU Confinement	$100/$100 per day, limited to 15 day(s) per insured per benefit year.
Health Screening	$50 per day, limited to 1 day(s) per insured per benefit year.
Pre-Existing Conditions Limitation - A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	Not Applicable (See Limitations and Exclusions section for details on treatment of maternity)
Portability - Allows you to take your Hospital Indemnity coverage with you if you terminate employment.	Included

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

Please print clearly and mark carefully.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Oct 17, 2022

Drop Coverage:

q Drop Employee q Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: ____-_____-_____

q Termination of Employment q Retirement

Last Day Worked: _____-_____-_____

q Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

q Critical Illness

q Accident q Employee q Spouse q Child(ren)

q Hospital Indemnity q Employee q Spouse q Child(ren)

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

q Covered under another insurance plan

q Other_____

(additional information may be required)

Critical Illness Coverage: You must be enrolled to cover your dependents

Benefit reductions apply. Please see plan administrator.

Employee

Insurance Amount: q $10,000 q $20,000

q I do not want this coverage.

Spouse

Insurance Amount: Up to 50% of the employee's amount to a maximum of $10,000

q $5,000 q $10,000

q I do not want this coverage.

Dependent/Child(ren)

Insurance Amount: q 25% of the employee's amount

q I do not want this coverage.

Accident Coverage You must be enrolled to cover your dependents.

Your Semi-monthly premium	Employee Only	Employee & Spouse	Employee & Dependent/Child(ren)	Employee, Spouse & Dependent/Child(ren)
	q	q	q	q

q I do not want this coverage.

I acknowledge and consent to receiving electronic copies of applicable insurance-related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

I consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by giving thirty (30) days prior written notice.

I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

NOTICE: This coverage under the policy may be issued if you have minimum essential coverage within the meaning of section 500A(f) of the Internal Revenue Code. By signing below, you are confirming that you have other health coverage.

SIGNATURE OF EMPLOYEE X _____ DATE _____

Fraud Warning Statements

Guardian Group Plan Number 00543094 Please print employee name:

New MexicoANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRE

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER