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AMERICAN LIBRARY ASSOCIATION  
ALL OTHER ELIGIBLE EMPLOYEES  
Group Number: 00543094

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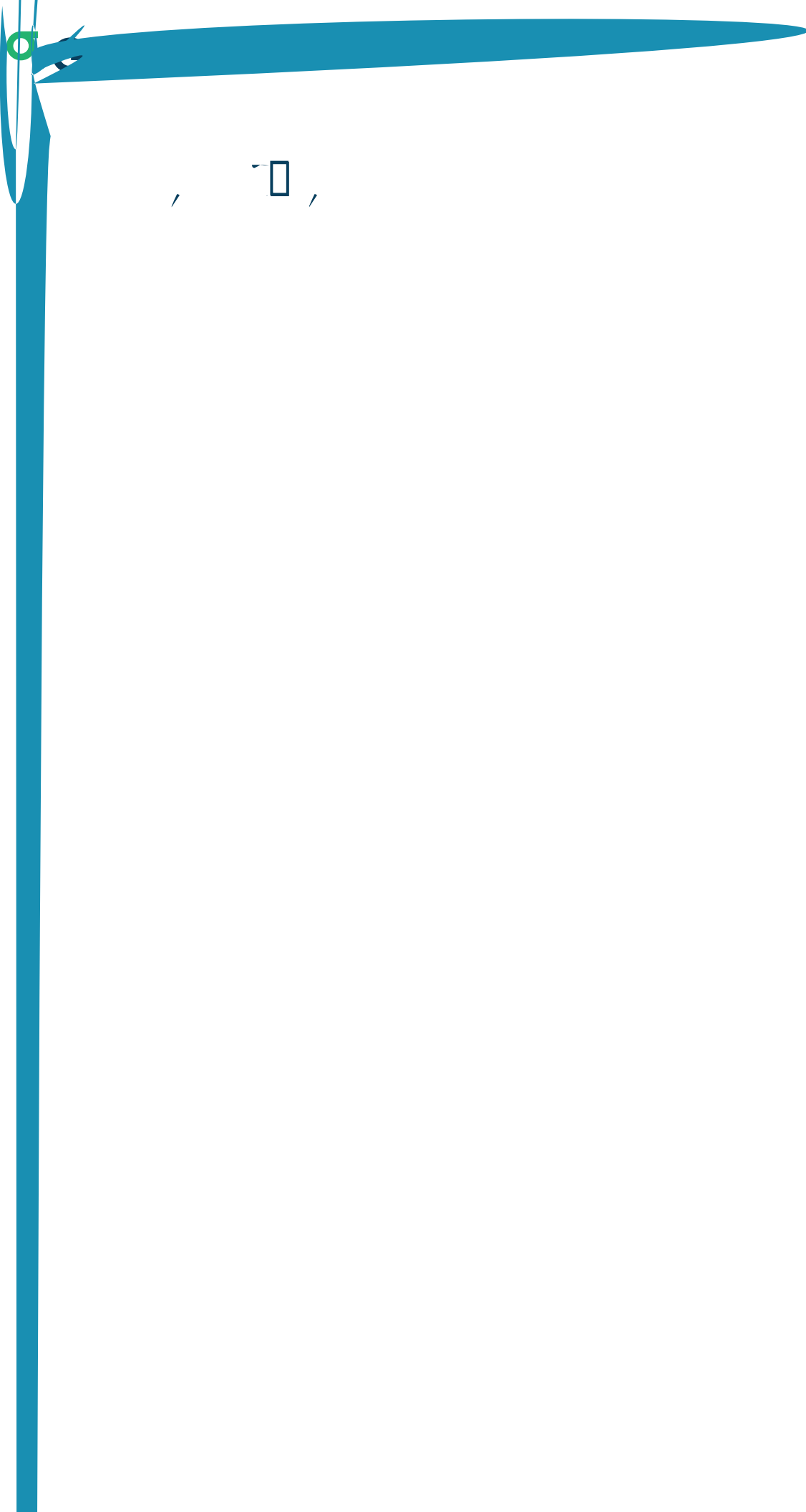
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## Hospital Indemnity

### 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.

**Drop Coverage:**

Drop Employee  Drop Dependents

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

Last Day of Coverage: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Termination of Employment  Retirement

Last Day Worked: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Other Event: \_\_\_\_\_

Date of Event: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Coverage Being Dropped:**

Critical Illness

Accident  Employee  Spouse  Child(ren)

Hospital Indemnity  Employee  Spouse  Child(ren)

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

Covered under another insurance plan

Other \_\_\_\_\_

(additional information may be required)

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

Benefit reductions apply. Please see plan administrator.

Employee

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

I do not want this coverage.

Spouse

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

\$5,000  \$10,000

I do not want this coverage.

Dependent/Child(ren)

Insurance Amount:  25% of the employee's amount

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)

I do not want this coverage.



- I acknowledge and consent to receiving electronic copies of applicable ~~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~~ messages, regarding my coverage(s). I may change this election only by providing (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 false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, ~~is~~ 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  \_\_\_\_\_

Enrollment Kit 00543094, 0001, EN

Fraud Warning Statements

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

