**Employer:**
Alabama A & M University
4900 Meridian Street
113 Patton Hall
Normal, AL 35762

About Yourself

Print clearly in black or blue ink.

First, Middle Initial, Last Name

Sex
- M
- F

Date of Birth (mm/dd/yyyy)

Social Security Number

Address

City

State

Zip

Preferred E-mail

Day Phone

Eve Phone

Job Title

Work Status
- Full-Time
- Part-Time
- Retired
- COBRA/State Continuation

Date work status began

Annual Salary/Earnings

Are you married?
- Yes
- No

Do you have children or other dependents?
- Yes
- No

About Your Dependents

A sheet with information about additional dependents is attached.

Spouse First, Middle Initial, Last Name

Sex
- M
- F

Date of Birth (mm/dd/yyyy)

Social Security Number

Marriage Date (mm/dd/yyyy)

State of Residence:

Child 1

Sex
- M
- F

Date of Birth (mm/dd/yyyy)

Full-time student, at (school):

City/State:

Attending Since

State of Residence:

Child 2

Sex
- M
- F

Date of Birth (mm/dd/yyyy)

Full-time student, at (school):

City/State:

Attending Since

State of Residence:

Child 3

Sex
- M
- F

Date of Birth (mm/dd/yyyy)

Full-time student, at (school):

City/State:

Attending Since

State of Residence:

Child 4

Sex
- M
- F

Date of Birth (mm/dd/yyyy)

Full-time student, at (school):

City/State:

Attending Since

State of Residence:

To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages.

- Basic Life
- Voluntary Life
- Long Term Disability
- Short Term Disability
- Dental
- Vision

A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exemption. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Questions? Call the Guardian Helpline (888) 600-1600
www.guardianlife.com

Enrollment Kit 00367734, 0003, EN

DATE FORM PUBLISHED: Oct 29, 2012
YOUR BASIC LIFE COVERAGE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Policy Amount
Employee ☐ $50,000

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy $ __________

Name your beneficiaries

Primary Beneficiary 1 First, Middle Initial, Last Name
Relationship to Employee
Percent %

Primary Beneficiary 2
%

Contingent Beneficiary
%

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

CHOOSE YOUR VOLUNTARY TERM LIFE COVERAGE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Check one box only

Employee Policy Amount

☑ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $60,000
☑ $70,000 ☐ $80,000 ☐ $90,000 ☐ $100,000 ☐ $110,000 ☐ $120,000
☑ $130,000 ☐ $140,000 ☐ $150,000* ☐ $160,000 ☐ $170,000 ☐ $180,000
☑ $190,000 ☐ $200,000**

$ __________

*Guarantee Issue Amount
**Guarantee Issue Amount plus Additional Amount
Note: You must answer additional health questions and complete Evidence of Insurability if necessary to qualify for this policy amount.

☐ I waive this coverage

Add Voluntary Life for Spouse

Check one box only

☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000* ☐ $30,000
☐ $35,000 ☐ $40,000 ☐ $45,000 ☐ $50,000** ☐ $55,000 ☐ $60,000
☐ $65,000 ☐ $70,000 ☐ $75,000 ☐ $80,000 ☐ $85,000 ☐ $90,000
☐ $95,000 ☐ $100,000

*Guarantee Issue Amount
**Guarantee Issue Amount plus Additional Amount
Note: You must answer additional health questions and complete Evidence of Insurability if necessary to qualify for this policy amount.

☐ I waive this coverage

The amount may not be more than 50% of the employee amount for Voluntary Life.

Add Voluntary Life for Child(ren)

Check one box only

☐ $10,000*

*Guarantee Issue Amount

☐ I waive this coverage

The amount may not be more than 10% of the employee amount for Voluntary Life.

☐ A separate sheet for Voluntary Term Life beneficiaries is attached if they are not the same as those named for Basic Life.

IMPORTANT NOTES

☐ If you waive life or disability coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person’s insurability. Guardian reserves the right to reject your request.

☐ Children will not be covered until they reach 14 days.

☐ Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Voluntary Life and/or Guardian Universal Life.
CHOOSING YOUR SHORT-TERM DISABILITY (STD) COVERAGE

- Weekly Benefit
  - ☐ 60% of salary to a maximum of $1,500
  - ☐ I waive this coverage.

CHOOSING YOUR LONG-TERM DISABILITY (LTD) COVERAGE

- Monthly Benefit
  - ☐ 50% of salary to a maximum of $5,000
  - ☐ I waive this coverage.

IMPORTANT NOTES

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

CHOOSING YOUR DENTAL COVERAGE

- Check one box only

<table>
<thead>
<tr>
<th>Your monthly premium</th>
<th>PPO</th>
<th></th>
<th>☐ I waive this coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee alone</td>
<td>☐ $25.23</td>
<td>☐ I waive this coverage</td>
<td></td>
</tr>
<tr>
<td>Entire family</td>
<td>☐ $69.89</td>
<td>☐ I waive this coverage</td>
<td></td>
</tr>
</tbody>
</table>

If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.

Reason for Loss of coverage: ☐ Termination of Employment ☐ Divorce ☐ Death of Spouse ☐ Termination or Expiration of coverage

Date of coverage loss / /

If you are waiving coverage, are you covered under another dental plan? ☐ Yes ☐ No

If you are waiving dependent coverage, are your dependents covered under another dental plan? ☐ Yes ☐ No

IMPORTANT NOTES

- Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

CHOOSING YOUR VISION COVERAGE

- Check one box only

<table>
<thead>
<tr>
<th>Your monthly premium</th>
<th>Exam Plus Allowance</th>
<th>☐ I waive this coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee alone</td>
<td>☐ $13.78</td>
<td>☐ I waive this coverage</td>
</tr>
<tr>
<td>Entire family</td>
<td>☐ $37.88</td>
<td>☐ I waive this coverage</td>
</tr>
</tbody>
</table>

If you are waiving coverage, are you covered under another vision plan? ☐ Yes ☐ No

If you are waiving dependent coverage, are your dependents covered under another vision plan? ☐ Yes ☐ No

IMPORTANT NOTES

- Proof of insurability does not apply to vision, but if you waive vision coverage and later decide to enroll, you may be subject to delays in enrollment.
- Your plan includes a One Year Lock-In/Lock-Out Provision - Your election to enroll in or waive vision coverage must remain in effect until your plan’s next annual vision enrollment period.
MEDICAL HISTORY

Complete the following question if you are enrolling for Voluntary Life and electing an amount above the Guarantee Issue Amount:

In the last 6 months have you or any of your dependents received medical care, including treatment, consultation, services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; any condition related to AIDS or AIDS Related Complex; or any other Chronic Condition?

☐ Yes, I have ☐ Yes, my spouse has ☐ Yes, my child has ☐ No

An Evidence of Insurability form must be completed for any person with a "Yes" answer to the question above.

SIGNATURE

☐ I hereby apply for the group benefit(s) that I have chosen above.
☐ I understand that I must meet eligibility requirements for all coverages that I have chosen above.
☐ I understand that I must be actively at work or my life and/or disability coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
☐ I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
☐ I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
☐ I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.

☐ I acknowledge and agree that Guardian may provide me information concerning benefits, including explanation of benefit statements and other claims related information solely in electronic format as permitted by law. I may change this election only by providing Guardian thirty (30) day prior written notice.
☐ I understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
☐ I attest that the information provided above is true and correct to the best of my knowledge.
☐ Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SIGNATURE OF EMPLOYEE X

DATE