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

Please print clearly and mark carefully.

Employer Name: **Acemco Inc**	Group Plan Number: **00497833**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ❑ Re-Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change ❑ Increase Amount ❑ Family Status Change

Class: All Other Eligible Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:
First, MI, Last Name:

Social Security Number
___ - ___ - ____

Address	City	State	Zip

Gender: ❑ M ❑ F Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) -

Email Address:

Are you married or do you have a spouse? ❑ Yes ❑ No
Do you have children or other dependents? ❑ Yes ❑ No

Date of marriage/union: ____ - ____ - ____
Placement date of adopted child: ____ - ____ - ____

About Your Job: Hours worked per week: _____ Job Title:

Work Status: ❑ Active ❑ Retired ❑ Cobra/State Continuation	Date of full time hire: ____ - ____ - ____	Annual Salary: $_____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. 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 exception. 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.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender ❑ M ❑ F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ❑ Student (post high school) ❑ Disabled ❑ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Oct 24, 2014

Guardian Group Plan Number: **00497833** Please print employee name:

Voluntary Term Life Coverage: **You must be enrolled to cover your dependents.** ***Benefit reductions apply. Please see plan administrator.***

Employee

Policy Amount ***Check one box only***

❑ $25,000 ❑ $50,000 ❑ $75,000 ❑ $100,000 ❑ $125,000 ❑ **$150,000***

**Guarantee Issue Amount*

❑ I do not want this coverage

***Add* Voluntary Life for Spouse**

❑ 100% of employee's amount to maximum $150,000 $_____

The Guarantee Issue Amount is $50,000.

The amount may not be more than 100% of the employee amount for Voluntary Life.

❑ I do not want this coverage

***Add* Voluntary Life for Dependent/Child(ren)**

❑ 10% of employee's amount to maximum $10,000 $_____

The Guarantee Issue Amount is $10,000.

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

❑ I do not want this coverage

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.

Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life, please name below.

Primary Beneficiaries:

Name:_____ **Social Security Number:** ___-___-____ %_____

Date of Birth (mm-dd-yy): ___-___-___ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Name:_____ **Social Security Number:** ___-___-____ %_____

Date of Birth (mm-dd-yy): ___-___-___ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

Contingent Beneficiary:_____ **Social Security Number:** ___-___-____

Date of Birth (mm-dd-yy): ___-___-___ **Address/City/State/Zip:**_____

Phone: ( ) - **Relationship to Employee:**_____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Cancer Coverage **You must be enrolled to cover your dependents.** **Check only one box.**

Your Weekly premium		Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: Advantage Plan	<30	❑ $1.18	❑ $2.68	❑ $1.96	❑ $3.46
	30-39	❑ $2.23	❑ $5.10	❑ $3.01	❑ $5.88
	40-49	❑ $4.60	❑ $10.09	❑ $5.38	❑ $10.87
	50-59	❑ $8.59	❑ $17.50	❑ $9.37	❑ $18.28
	60-64	❑ $13.09	❑ $25.58	❑ $13.87	❑ $26.36
	65+	❑ $17.74	❑ $33.89	❑ $18.52	❑ $34.67

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