Guardian

J SOLUTIONS, INC.

Life Benefit Summary

Group Number: 00476055

About Your Benefits:

Your family depends on you in many ways and you've worked hard to ensure their financial security. But if something happened to you, will your family be protected? Will your loved ones be able to stay in their home, pay bills, and prepare for the future. Life insurance provides a financial benefit that your family can depend on. And getting it at work is easier, more convenient and more affordable than doing it on your own. If you have financial dependents- a spouse, children or aging parents, having life insurance is a responsible and a smart decision. Enroll today to secure their future!

What Your Benefits Cover:

	VOLUNTARY TERM LIFE
Employee Benefit	$25,000 increments to a maximum of $100,000. See Cost Illustration page for details.
Spouse/Domestic Partner‡ Benefit	$5,000 increments to a maximum of $25,000. See Cost Illustration page for details.
Child Benefit	Your dependent children age 14 days to 26 years. $1,000 increments to a maximum of $10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	We Guarantee Issue coverage up to: Employee $10,000. Spouse $5,000. Dependent children $10,000.
Premiums	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits

‡ **Spouse coverage terminates at age 70.**

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style. To help you assess your needs, you can also go to Guardian Anytime and view a video: https://www.guardiananytime.com/gafd/wps/portal/fdhome/employees/products-coverage/life

Policy Election Amount	Monthly premiums displayed. Policy Election Cost Per Age Bracket								
Employee	**< 30**	**30–34**	**35–39**	**40–44**	**45–49**	**50–54**	**55–59**	**60–64**	**65–69†**
$25,000	$1.00	$1.25	$2.00	$3.75	$5.50	$8.50	$13.25	$20.75	$33.50
$50,000	$2.00	$2.50	$4.00	$7.50	$11.00	$17.00	$26.50	$41.50	$67.00
$75,000	$3.00	$3.75	$6.00	$11.25	$16.50	$25.50	$39.75	$62.25	$100.50
$100,000	$4.00	$5.00	$8.00	$15.00	$22.00	$34.00	$53.00	$83.00	$134.00
Policy Election Amount									
Spouse/DP									
$5,000	$.20	$.25	$.40	$.75	$1.10	$1.70	$2.65	$4.15	$6.70
$10,000	$.40	$.50	$.80	$1.50	$2.20	$3.40	$5.30	$8.30	$13.40
$15,000	$.60	$.75	$1.20	$2.25	$3.30	$5.10	$7.95	$12.45	$20.10
$20,000	$.80	$1.00	$1.60	$3.00	$4.40	$6.80	$10.60	$16.60	$26.80
$25,000	$1.00	$1.25	$2.00	$3.75	$5.50	$8.50	$13.25	$20.75	$33.50
Policy Election Amount									
Child(ren)									
$1,000	$0.17	$0.17	$0.17	$0.17	$0.17	$0.17	$0.17	$0.17	$0.17
$2,000	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34
$3,000	$0.51	$0.51	$0.51	$0.51	$0.51	$0.51	$0.51	$0.51	$0.51
$4,000	$0.68	$0.68	$0.68	$0.68	$0.68	$0.68	$0.68	$0.68	$0.68
$5,000	$0.85	$0.85	$0.85	$0.85	$0.85	$0.85	$0.85	$0.85	$0.85
$6,000	$1.02	$1.02	$1.02	$1.02	$1.02	$1.02	$1.02	$1.02	$1.02
$7,000	$1.19	$1.19	$1.19	$1.19	$1.19	$1.19	$1.19	$1.19	$1.19
$8,000	$1.36	$1.36	$1.36	$1.36	$1.36	$1.36	$1.36	$1.36	$1.36
$9,000	$1.53	$1.53	$1.53	$1.53	$1.53	$1.53	$1.53	$1.53	$1.53
$10,000	$1.70	$1.70	$1.70	$1.70	$1.70	$1.70	$1.70	$1.70	$1.70

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.
Premiums for Voluntary Life Increase in five-year increments
‡**Spouse/DP coverage premium is based on Employee age. Coverage for the spouse terminates at spouse's age 70.**
†Benefit reductions apply.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-1-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

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

Please print clearly and mark carefully.

Employer Name: **J SOLUTIONS, INC.**	Group Plan Number: **00476055**	Benefits Effective:_______________
PLEASE CHECK APPROPRIATE BOX Initial Enrollment Re-Enrollment Add Employee/Dependents Drop/Refuse Coverage Information Change Increase Amount Family Status Change		

Class:______________________	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 dependent tax exemption. Dependent 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.**

Name	Add/Drop	Gender	Social Security Number / Date of Birth	Status
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

Child/Dependent 3: 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 4: 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

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:

Voluntary Life   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)

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***

$10,000* $25,000 $50,000 $75,000 $100,000

*Guarantee Issue Amount. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

I do not want this coverage

Add **Voluntary Life for Spouse**

Policy Amount

$5,000* $10,000 $15,000 $20,000 $25,000

**Guarantee Issue Amount*

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

I do not want this coverage

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

Policy Amount

$1,000 $2,000 $3,000 $4,000 $5,000 $6,000

$7,000 $8,000 $9,000 **$10,000***

**Guarantee Issue Amount*

****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.

LIFE INSURANCE *continued*

Name your beneficiaries: (Primary beneficiary percentages must total 100%)
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.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Signature

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 understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

I understand that the premium amounts shown above are estimations and are for illustrative purposes only.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.

If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.

Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.

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 agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

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 voluntarily agree to receiving electronic copies. I understand that I may withdraw this election by providing thirty (30) day prior written notice to Guardian.
I do not agree to receiving electronic. I would like to received written communication from Guardian. I may change this election only by providing thirty (30) day 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.

The laws of New York require the following statement appear: If you are not a resident of New York this statement does not apply to you: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X ______________________________ **DATE** ______________

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Ohio: 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 is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: 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 have violated state law.