

ALL ELIGIBLE EXECUTIVES NOT LOCATED IN CALIFORNIA
00477073/00511190



ESSEX PORTFOLIO, L.P.

Benefits Plan

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

- Dental
- Life
- Long Term Disability

Find a Provider Online. It's easy.

- Search by: specialty, languages spoken, and more
- Side-by-side comparisons of provider information
- Get maps and driving direction
- Save your search criteria for easy access ...and much more

Go to www.GuardianAnytime.com. Click on "Find a Provider"

Questions? Concerns?

Helpline (888) 600-1600

Call weekdays, 8:00AM to 8:30PM, EST. And refer to your plan number: 00477073

Dental Plans

Option 1 or 2: PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	Option 1: PPO		Option 2: PPO	
	DentalGuard Preferred		DentalGuard Preferred	
Network	DentalGuard Preferred		DentalGuard Preferred	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$50	\$50	\$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Preventive Care	100%	100%	100%	100%
Basic Care	90%	80%	90%	80%
Major Care	60%	50%	60%	50%
Orthodontia	50%	50%	50%	50%
Annual Maximum Benefit	\$1000	\$1000	\$2000	\$2000
Lifetime Orthodontia Maximum	\$1500		\$2000	
Dependent Age Limits	26		26	

YOUR GUARDIAN PLAN OFFERS:

Orthodontia coverage for adults and children

No charge for preventive care (subject to plan limits)

Great selection of dentists convenient to you - yours is likely in our network!

Reliable claims payment four days on average

Find out if your dentist is in Guardian's network at www.GuardianAnytime.com

Let Guardian put its 30-plus years of dental benefits experience to work for you and your family.

CATEGORY	PLAN DETAILS	Option 1: PPO <i>Plan pays (on average)</i>		Option 2: PPO <i>Plan pays (on average)</i>	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 19		Under Age 19	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
Basic Care	X-rays	100%	100%	100%	100%
	Fillings†	90%	80%	90%	80%
	Perio Surgery	90%	80%	90%	80%
	Periodontal Maintenance	90%	80%	90%	80%
	Frequency:	Once Every 3 Months		Once Every 3 Months	
	Root Canal	90%	80%	90%	80%
	Scaling & Root Planing (per quadrant)	90%	80%	90%	80%
	Simple Extractions	90%	80%	90%	80%
	Surgical Extractions	90%	80%	90%	80%
Major Care	Anesthesia*	60%	50%	60%	50%
	Bridges and Dentures	60%	50%	60%	50%
	Dental Implants	60%	50%	60%	50%
	Inlays, Onlays, Veneers**	60%	50%	60%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	60%	50%	60%	50%
	Single Crowns	60%	50%	60%	50%
Orthodontia	Orthodontia	50%	50%	50%	50%
	Limits:	Adults & Child(ren)		Adults & Child(ren)	

Please note: The plan details listed here are some of the most common services related to dental coverage. The co-insurance percentages for the PPO plan options correspond to the coverage categories of Preventive, Basic, Major and Orthodontia listed in the table above.

Some services may be paid under a different category than listed. The actual co-insurance shown reflects your plan's coverage.

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filling material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia - restrictions apply. †For PPO and or Indemnity members, Fillings- restrictions may apply to composite fillings.

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.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed

above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.

- **For PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan.R3-DG2000



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: 05/01/2016

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at www.guardianlife.com/privacy-policy.

What is Protected Health Information (PHI):

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes:

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures.

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use or disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

Your Rights with Regard to Your Protected Health Information (PHI):

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI may require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures. An ‘accounting of disclosures’ is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Accounting of Disclosure requests is available at www.guardianlife.com/privacy-policy.

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications. You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

Your Right to Amend Your PHI If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention: Guardian Corporate Privacy Officer
National Operations

Address: The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 981573
El Paso, TX 79998-1573

Life Plans

Basic Life Your employer provides Basic Life Coverage for all full time employees in the amount of 200% of your annual salary, to a maximum of \$500,000. Your Basic Life coverage includes Enhanced Accidental Death and Dismemberment coverage equal to one times the employee's life benefits.

You may elect Voluntary Term coverage.

Premiums will be deducted from your monthly payroll check.

COVERAGE OPTIONS	VOLUNTARY TERM LIFE
Employee Benefit	\$10,000 increments to a maximum of \$500,000. See Cost Illustration page for details.
Spouse/domestic partner benefit	\$5,000 increments to a maximum of \$250,000. See Cost Illustration page for details.‡
Child benefit—children age birth† to 26 years	\$1,000 increments to a maximum of \$10,000. Subject to state limits. See Cost Illustration page for details.

Subject to coverage limits

† *Infant coverage is limited based on age.*

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

Premiums for Voluntary Life increase in five-year increments. See enrollment form for details.

YOUR GUARDIAN PLAN OFFERS:

Enhanced Accidental Death and Dismemberment coverage which includes: catastrophic loss, Common carrier, Child education, Day care expense, Repatriation and Spousal education and retraining.

Low group rates

Family coverage for spouse/domestic partner and children

Portability to take your coverage with you if you leave your job.

Reliable claims payments

Did you know?

Less than 45% of U.S. adults have individual life coverage. Of those who are insured, more than 65% don't have enough coverage.

PLAN DETAILS	BASIC LIFE	VOLUNTARY TERM LIFE
Guarantee Issue	Guarantee Issue coverage up to \$500,000 per employee	We Guarantee Issue coverage up to: Employee \$200,000. Spouse \$50,000. Dependent children \$10,000.
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next 5 year age group
Portability	Yes, with age and other restrictions	Yes, with age and other restrictions
Conversion	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit	Yes	Yes
Waiver of Premiums	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions	33% at age 70, 66% at age 75	33% at age 70, 66% at age 75

EXCLUSIONS AND LIMITATIONS

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS For Basic Life:

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.
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.
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.

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS for Voluntary Term Life:

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.
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
Dependent coverage will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex (may vary by state).

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.

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.

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS for AD&D:

We pay no Accidental Death and Dismemberment (AD&D) benefits for an insured where death or dismemberment occurs:

As the result of a disease or a bodily infirmity; By declared or undeclared war or act of war or armed aggression, or while a member of any armed force. May vary by state; Through intentional self-injury; While driving without a valid driver's license; While legally intoxicated; While participating in civil disorder or committing a felony; Traveling on any type of aircraft while having any duties on that aircraft; While voluntarily using a non-prescription controlled substance; GP-1-R-ADCL1-00 et al.

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.

Life Cost Illustration

Voluntary Life Cost Illustration

Employee	Policy Election Amount	Monthly premiums displayed. Policy Election Cost Per Age Bracket								
		< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69 [†]
\$20,000	\$1.20	\$1.60	\$1.80	\$2.00	\$3.00	\$4.60	\$8.60	\$13.20	\$25.40	
\$30,000	\$1.80	\$2.40	\$2.70	\$3.00	\$4.50	\$6.90	\$12.90	\$19.80	\$38.10	
\$40,000	\$2.40	\$3.20	\$3.60	\$4.00	\$6.00	\$9.20	\$17.20	\$26.40	\$50.80	
\$50,000	\$3.00	\$4.00	\$4.50	\$5.00	\$7.50	\$11.50	\$21.50	\$33.00	\$63.50	
\$60,000	\$3.60	\$4.80	\$5.40	\$6.00	\$9.00	\$13.80	\$25.80	\$39.60	\$76.20	
\$70,000	\$4.20	\$5.60	\$6.30	\$7.00	\$10.50	\$16.10	\$30.10	\$46.20	\$88.90	
\$80,000	\$4.80	\$6.40	\$7.20	\$8.00	\$12.00	\$18.40	\$34.40	\$52.80	\$101.60	
\$90,000	\$5.40	\$7.20	\$8.10	\$9.00	\$13.50	\$20.70	\$38.70	\$59.40	\$114.30	
\$100,000	\$6.00	\$8.00	\$9.00	\$10.00	\$15.00	\$23.00	\$43.00	\$66.00	\$127.00	
\$110,000	\$6.60	\$8.80	\$9.90	\$11.00	\$16.50	\$25.30	\$47.30	\$72.60	\$139.70	
\$120,000	\$7.20	\$9.60	\$10.80	\$12.00	\$18.00	\$27.60	\$51.60	\$79.20	\$152.40	
\$130,000	\$7.80	\$10.40	\$11.70	\$13.00	\$19.50	\$29.90	\$55.90	\$85.80	\$165.10	
\$140,000	\$8.40	\$11.20	\$12.60	\$14.00	\$21.00	\$32.20	\$60.20	\$92.40	\$177.80	
\$150,000	\$9.00	\$12.00	\$13.50	\$15.00	\$22.50	\$34.50	\$64.50	\$99.00	\$190.50	
\$160,000	\$9.60	\$12.80	\$14.40	\$16.00	\$24.00	\$36.80	\$68.80	\$105.60	\$203.20	
\$170,000	\$10.20	\$13.60	\$15.30	\$17.00	\$25.50	\$39.10	\$73.10	\$112.20	\$215.90	
\$180,000	\$10.80	\$14.40	\$16.20	\$18.00	\$27.00	\$41.40	\$77.40	\$118.80	\$228.60	
\$190,000	\$11.40	\$15.20	\$17.10	\$19.00	\$28.50	\$43.70	\$81.70	\$125.40	\$241.30	
\$200,000	\$12.00	\$16.00	\$18.00	\$20.00	\$30.00	\$46.00	\$86.00	\$132.00	\$254.00	
\$210,000	\$12.60	\$16.80	\$18.90	\$21.00	\$31.50	\$48.30	\$90.30	\$138.60	\$266.70	
\$220,000	\$13.20	\$17.60	\$19.80	\$22.00	\$33.00	\$50.60	\$94.60	\$145.20	\$279.40	
\$230,000	\$13.80	\$18.40	\$20.70	\$23.00	\$34.50	\$52.90	\$98.90	\$151.80	\$292.10	
\$240,000	\$14.40	\$19.20	\$21.60	\$24.00	\$36.00	\$55.20	\$103.20	\$158.40	\$304.80	
\$250,000	\$15.00	\$20.00	\$22.50	\$25.00	\$37.50	\$57.50	\$107.50	\$165.00	\$317.50	

Voluntary Life Cost Illustration *continued*

	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69 [†]
\$260,000	\$15.60	\$20.80	\$23.40	\$26.00	\$39.00	\$59.80	\$111.80	\$171.60	\$330.20
\$270,000	\$16.20	\$21.60	\$24.30	\$27.00	\$40.50	\$62.10	\$116.10	\$178.20	\$342.90
\$280,000	\$16.80	\$22.40	\$25.20	\$28.00	\$42.00	\$64.40	\$120.40	\$184.80	\$355.60
\$290,000	\$17.40	\$23.20	\$26.10	\$29.00	\$43.50	\$66.70	\$124.70	\$191.40	\$368.30
\$300,000	\$18.00	\$24.00	\$27.00	\$30.00	\$45.00	\$69.00	\$129.00	\$198.00	\$381.00
\$310,000	\$18.60	\$24.80	\$27.90	\$31.00	\$46.50	\$71.30	\$133.30	\$204.60	\$393.70
\$320,000	\$19.20	\$25.60	\$28.80	\$32.00	\$48.00	\$73.60	\$137.60	\$211.20	\$406.40
\$330,000	\$19.80	\$26.40	\$29.70	\$33.00	\$49.50	\$75.90	\$141.90	\$217.80	\$419.10
\$340,000	\$20.40	\$27.20	\$30.60	\$34.00	\$51.00	\$78.20	\$146.20	\$224.40	\$431.80
\$350,000	\$21.00	\$28.00	\$31.50	\$35.00	\$52.50	\$80.50	\$150.50	\$231.00	\$444.50
\$360,000	\$21.60	\$28.80	\$32.40	\$36.00	\$54.00	\$82.80	\$154.80	\$237.60	\$457.20
\$370,000	\$22.20	\$29.60	\$33.30	\$37.00	\$55.50	\$85.10	\$159.10	\$244.20	\$469.90
\$380,000	\$22.80	\$30.40	\$34.20	\$38.00	\$57.00	\$87.40	\$163.40	\$250.80	\$482.60
\$390,000	\$23.40	\$31.20	\$35.10	\$39.00	\$58.50	\$89.70	\$167.70	\$257.40	\$495.30
\$400,000	\$24.00	\$32.00	\$36.00	\$40.00	\$60.00	\$92.00	\$172.00	\$264.00	\$508.00
\$410,000	\$24.60	\$32.80	\$36.90	\$41.00	\$61.50	\$94.30	\$176.30	\$270.60	\$520.70
\$420,000	\$25.20	\$33.60	\$37.80	\$42.00	\$63.00	\$96.60	\$180.60	\$277.20	\$533.40
\$430,000	\$25.80	\$34.40	\$38.70	\$43.00	\$64.50	\$98.90	\$184.90	\$283.80	\$546.10
\$440,000	\$26.40	\$35.20	\$39.60	\$44.00	\$66.00	\$101.20	\$189.20	\$290.40	\$558.80
\$450,000	\$27.00	\$36.00	\$40.50	\$45.00	\$67.50	\$103.50	\$193.50	\$297.00	\$571.50
\$460,000	\$27.60	\$36.80	\$41.40	\$46.00	\$69.00	\$105.80	\$197.80	\$303.60	\$584.20
\$470,000	\$28.20	\$37.60	\$42.30	\$47.00	\$70.50	\$108.10	\$202.10	\$310.20	\$596.90
\$480,000	\$28.80	\$38.40	\$43.20	\$48.00	\$72.00	\$110.40	\$206.40	\$316.80	\$609.60
\$490,000	\$29.40	\$39.20	\$44.10	\$49.00	\$73.50	\$112.70	\$210.70	\$323.40	\$622.30
\$500,000	\$30.00	\$40.00	\$45.00	\$50.00	\$75.00	\$115.00	\$215.00	\$330.00	\$635.00

Voluntary Life Cost Illustration *continued*

	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69 [†]
Policy Election Amount									
Spouse/DP									
\$10,000	\$.60	\$.80	\$.90	\$1.00	\$1.50	\$2.30	\$4.30	\$6.60	\$12.70
\$12,000	\$.72	\$.96	\$1.08	\$1.20	\$1.80	\$2.76	\$5.16	\$7.92	\$15.24
\$15,000	\$.90	\$1.20	\$1.35	\$1.50	\$2.25	\$3.45	\$6.45	\$9.90	\$19.05
\$20,000	\$1.20	\$1.60	\$1.80	\$2.00	\$3.00	\$4.60	\$8.60	\$13.20	\$25.40
\$25,000	\$1.50	\$2.00	\$2.25	\$2.50	\$3.75	\$5.75	\$10.75	\$16.50	\$31.75
\$30,000	\$1.80	\$2.40	\$2.70	\$3.00	\$4.50	\$6.90	\$12.90	\$19.80	\$38.10
\$35,000	\$2.10	\$2.80	\$3.15	\$3.50	\$5.25	\$8.05	\$15.05	\$23.10	\$44.45
\$40,000	\$2.40	\$3.20	\$3.60	\$4.00	\$6.00	\$9.20	\$17.20	\$26.40	\$50.80
\$45,000	\$2.70	\$3.60	\$4.05	\$4.50	\$6.75	\$10.35	\$19.35	\$29.70	\$57.15
\$50,000	\$3.00	\$4.00	\$4.50	\$5.00	\$7.50	\$11.50	\$21.50	\$33.00	\$63.50
\$55,000	\$3.30	\$4.40	\$4.95	\$5.50	\$8.25	\$12.65	\$23.65	\$36.30	\$69.85
\$60,000	\$3.60	\$4.80	\$5.40	\$6.00	\$9.00	\$13.80	\$25.80	\$39.60	\$76.20
\$65,000	\$3.90	\$5.20	\$5.85	\$6.50	\$9.75	\$14.95	\$27.95	\$42.90	\$82.55
\$70,000	\$4.20	\$5.60	\$6.30	\$7.00	\$10.50	\$16.10	\$30.10	\$46.20	\$88.90
\$75,000	\$4.50	\$6.00	\$6.75	\$7.50	\$11.25	\$17.25	\$32.25	\$49.50	\$95.25
\$80,000	\$4.80	\$6.40	\$7.20	\$8.00	\$12.00	\$18.40	\$34.40	\$52.80	\$101.60
\$85,000	\$5.10	\$6.80	\$7.65	\$8.50	\$12.75	\$19.55	\$36.55	\$56.10	\$107.95
\$90,000	\$5.40	\$7.20	\$8.10	\$9.00	\$13.50	\$20.70	\$38.70	\$59.40	\$114.30
\$95,000	\$5.70	\$7.60	\$8.55	\$9.50	\$14.25	\$21.85	\$40.85	\$62.70	\$120.65
\$100,000	\$6.00	\$8.00	\$9.00	\$10.00	\$15.00	\$23.00	\$43.00	\$66.00	\$127.00
\$105,000	\$6.30	\$8.40	\$9.45	\$10.50	\$15.75	\$24.15	\$45.15	\$69.30	\$133.35
\$110,000	\$6.60	\$8.80	\$9.90	\$11.00	\$16.50	\$25.30	\$47.30	\$72.60	\$139.70
\$115,000	\$6.90	\$9.20	\$10.35	\$11.50	\$17.25	\$26.45	\$49.45	\$75.90	\$146.05
\$125,000	\$7.50	\$10.00	\$11.25	\$12.50	\$18.75	\$28.75	\$53.75	\$82.50	\$158.75

Voluntary Life Cost Illustration *continued*

	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69 [†]
\$130,000	\$7.80	\$10.40	\$11.70	\$13.00	\$19.50	\$29.90	\$55.90	\$85.80	\$165.10
\$135,000	\$8.10	\$10.80	\$12.15	\$13.50	\$20.25	\$31.05	\$58.05	\$89.10	\$171.45
\$140,000	\$8.40	\$11.20	\$12.60	\$14.00	\$21.00	\$32.20	\$60.20	\$92.40	\$177.80
\$145,000	\$8.70	\$11.60	\$13.05	\$14.50	\$21.75	\$33.35	\$62.35	\$95.70	\$184.15
\$150,000	\$9.00	\$12.00	\$13.50	\$15.00	\$22.50	\$34.50	\$64.50	\$99.00	\$190.50
\$155,000	\$9.30	\$12.40	\$13.95	\$15.50	\$23.25	\$35.65	\$66.65	\$102.30	\$196.85
\$160,000	\$9.60	\$12.80	\$14.40	\$16.00	\$24.00	\$36.80	\$68.80	\$105.60	\$203.20
\$165,000	\$9.90	\$13.20	\$14.85	\$16.50	\$24.75	\$37.95	\$70.95	\$108.90	\$209.55
\$170,000	\$10.20	\$13.60	\$15.30	\$17.00	\$25.50	\$39.10	\$73.10	\$112.20	\$215.90
\$175,000	\$10.50	\$14.00	\$15.75	\$17.50	\$26.25	\$40.25	\$75.25	\$115.50	\$222.25
\$180,000	\$10.80	\$14.40	\$16.20	\$18.00	\$27.00	\$41.40	\$77.40	\$118.80	\$228.60
\$185,000	\$11.10	\$14.80	\$16.65	\$18.50	\$27.75	\$42.55	\$79.55	\$122.10	\$234.95
\$190,000	\$11.40	\$15.20	\$17.10	\$19.00	\$28.50	\$43.70	\$81.70	\$125.40	\$241.30
\$195,000	\$11.70	\$15.60	\$17.55	\$19.50	\$29.25	\$44.85	\$83.85	\$128.70	\$247.65
\$200,000	\$12.00	\$16.00	\$18.00	\$20.00	\$30.00	\$46.00	\$86.00	\$132.00	\$254.00
\$205,000	\$12.30	\$16.40	\$18.45	\$20.50	\$30.75	\$47.15	\$88.15	\$135.30	\$260.35
\$210,000	\$12.60	\$16.80	\$18.90	\$21.00	\$31.50	\$48.30	\$90.30	\$138.60	\$266.70
\$215,000	\$12.90	\$17.20	\$19.35	\$21.50	\$32.25	\$49.45	\$92.45	\$141.90	\$273.05
\$220,000	\$13.20	\$17.60	\$19.80	\$22.00	\$33.00	\$50.60	\$94.60	\$145.20	\$279.40
\$225,000	\$13.50	\$18.00	\$20.25	\$22.50	\$33.75	\$51.75	\$96.75	\$148.50	\$285.75
\$230,000	\$13.80	\$18.40	\$20.70	\$23.00	\$34.50	\$52.90	\$98.90	\$151.80	\$292.10
\$235,000	\$14.10	\$18.80	\$21.15	\$23.50	\$35.25	\$54.05	\$101.05	\$155.10	\$298.45
\$240,000	\$14.40	\$19.20	\$21.60	\$24.00	\$36.00	\$55.20	\$103.20	\$158.40	\$304.80
\$245,000	\$14.70	\$19.60	\$22.05	\$24.50	\$36.75	\$56.35	\$105.35	\$161.70	\$311.15
\$250,000	\$15.00	\$20.00	\$22.50	\$25.00	\$37.50	\$57.50	\$107.50	\$165.00	\$317.50

Voluntary Life Cost Illustration *continued*

	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69†
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.

As an eligible employee, you can purchase this coverage at the group premium levels illustrated above. For more details see enrollment form.

Subject to coverage limits

Premiums for Voluntary Life Increase in 5 year increments

Infant coverage is limited for the first two weeks of infant's life.

Spouse/DP coverage premium is based on Employee age.

†Benefit reductions apply. See plan details

WillPrep Services

Special bonus for participants in voluntary life plan

Your employer has worked with Guardian to make WillPrep Services available to eligible members with Voluntary Life plans. Keeping an up-to-date will is essential to ensuring that your assets are distributed as you intended, no matter the size of your estate. You may be avoiding creating a will because you believe you can't afford the time or legal expense. Now you can with WillPrep Services.

WillPrep Services offer support and guidance to help you properly prepare the documents necessary to preserve your family's financial security. WillPrep has a range of services including online planning documents, a resource library and access to professionals* to help with issues related to:

- | | | |
|-----------------------------------|------------------------------------|--------------------------|
| ▪ Advanced Health Care Directives | ▪ Financial Power of Attorney | ▪ Wills and Living Wills |
| ▪ Estate Taxes | ▪ Guardianship and Conservatorship | ▪ Resource Library |
| ▪ Executors & Probate | ▪ Healthcare Power of Attorney | ▪ Trusts |

For more information about WillPrep Services, go to www.ibhwillprep.com; User name: WillPrep; Password: GLIC09 or call 1-877-433-6789

*The Option of an attorney prepared will is available for a small fee.

WillPrep Services are provided by Integrated Behavioral Health, Inc., and its contractors. The Guardian Life Insurance Company of America (Guardian) does not provide any part of WillPrep Services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WillPrep Services at any time without notice. Legal services will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.

Disability Plans

Long-Term Disability Coverage

Provides benefits starting 90 days after you become disabled.

While disabled, your gross monthly benefit will be 60% of your salary, to a maximum of \$15000.

COVERAGE	LONG-TERM DISABILITY
Coverage amount	60% of salary to maximum \$15000/month
Maximum payment period	Social Security Normal Retirement Age
Accident benefits begin	Day 91
Illness benefits begin	Day 91
Waiting period	
Current employees	Planholder determines
New employees	Planholder determines

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.

YOUR GUARDIAN PLAN OFFERS:

Free employee assistance program, confidential advice and crisis intervention by phone from registered nurses and psychotherapists.

Premium payments waived once you begin receiving benefits.

Reliable claim payments

Did you know?

Most experts agree that after medical insurance, disability is the most important coverage to have.

Benefit information illustrated within this material reflects the plan covered by Guardian as of 06/08/2020

Questions? Call the Guardian Helpline (888) 600-1600

www.guardianlife.com

Enrollment Kit 00477073, 0002, EN

PLAN DETAILS**LONG-TERM DISABILITY**

Evidence of Insurability	Health Statement may be required
Guarantee Issue	We Guarantee Issue \$15000 in coverage
Minimum work hours/week	Planholder Determines
Plan covers on the job accidents	Yes
Pre-existing Conditions	3 months look back; 12 months after exclusion
Rehabilitation Benefit	Yes
Survivor Benefit	3 months

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- 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.
- 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.
- A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.
- For Long-Term Disability coverage, we pay no benefits for a disability caused or contributed to by a pre-existing condition unless the disability starts after you have been insured under this plan for a specified period of time. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA, DC PFML and WA PFML.



BENEFITS OFFSET NOTICE

Your Guardian Group Disability Policy (Policy) may provide that any Guardian Disability benefits you receive may be offset by Other Income/ Benefits you or your dependents receive while you are receiving Guardian Disability Benefits. This means that Guardian may deduct the amount of any Other/Income Benefit payments made to you or your dependents from your weekly or monthly Guardian Disability Benefit prior to issuing payment. Examples of Other Income Benefits described in your Policy include:

- U.S. Social Security Disability Income or Retirement Benefits
- Disability or Retirement Benefits payable from any other source, including state mandated disability plans, U.S. Railroad Retirement plan or similar U.S./Canadian plan
- Salary earned or paid during your disability period, including sick leave, paid time off, severance payments, bonuses and commissions
- Workers' Compensation benefits
- No-fault motor vehicle coverage benefits
- Distributions, profit sharing, royalties

Upon enrollment, please review your certificate booklet for the full definition of Other Income Benefits and provisions pertaining benefit offsets and overpayment recovery. If you or your dependents are awarded any Other Income Benefits, including lump sum payments while you are receiving Guardian Disability benefits, you should contact Guardian promptly to calculate the appropriate offset amount and prevent an overpayment of benefits.

THE GUARDIAN LIFE INSURANCE COMPANY
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

1. Read Your Certificate Carefully

This outline of coverage provides a very brief description of some important features of your plan. This is not the insurance contract and only the actual plan provisions will control. The certificate itself sets forth, in detail, the rights and obligations of both you and Guardian Life Insurance Company. It is, therefore, important that you Read Your Certificate Carefully!

2. Disability Income Protection Coverage

This category of coverage is designed to provide, to persons insured, benefits for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the certificate. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

3. Benefits of the Plan

Sample definitions of disability and elimination period are presented below. The specific definitions that apply to your plan appear in your certificate. Read your certificate carefully.

Total Disability or Totally Disabled means that as a result of sickness or injury, you are not able to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation and you are not working in your usual occupation.

Substantial and material acts means the important tasks, functions and operations generally required by employers from those engaged in your usual occupation that cannot be reasonably omitted or modified.

In determining what substantial and material acts are necessary to pursue your usual occupation, we will first look at the specific duties required by the employer or job. If you are unable to perform one or more of these duties with reasonable continuity, we will then determine whether those duties are customarily required of other persons engaged in your usual occupation. If any specific, material duties required of you by the employer or job differ from the material duties customarily required of other persons engaged in your usual occupation, then we will not consider those duties in determining what substantial and material acts are necessary to pursue your usual occupation.

Usual occupation may be interpreted to mean the employment, business, trade or profession that involves the substantial and material acts of the occupation you were regularly performing for the employer when the disability began. Usual occupation is not necessarily limited to the specific job you performed for the employer.

Elimination Period means the period of time you must be disabled, due to a covered disability, before this plan's benefits are payable.

4. Limitations and Exclusions

Sample Pre-Existing Conditions Limitation and Exclusions are presented below. The Certificate sets forth in detail the specific limitation and exclusions applicable to your plan. Read your certificate carefully.

Pre-Existing Conditions

You are not covered for a disability caused or substantially contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition.

You have a pre-existing condition if:

- (a) You received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the three months immediately prior to the effective date of your insurance under the plan; or

You suffered from a physical, or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in your Application (i) for which you received a doctor's advice or treatment within three months before the effective date of your insurance under the plan, or (ii) which caused symptoms within three months before the effective date of your insurance under this plan for which a prudent person would usually seek medical advice or treatment; and

- (b) the disability caused or substantially contributed to by the condition begins in the first 12 months after the effective date of your insurance under the plan.

Exclusions

The plan does not pay benefits for disability caused by:

- (a) declared or undeclared war, act of war, or armed aggression;
- (b) service in the armed forces, National Guard, or military reserves of any state or country;
- (c) your taking part in a riot or civil disorder;
- (d) your commission of, or attempt to commit a felony, for which you have been convicted;
- (e) your being engaged in an illegal occupation; or
- (f) intentional self-inflicted injuries.

We do not pay any benefits for any period of disability:

- (1) during which you are confined to a facility as a result of your conviction of a crime; or
- (2) which starts before you are insured by the plan.

5. Renewability of the Policy

The Policy is issued for a term of one (1) year from the Policy date shown on the first page of the Policy. All Policy years and Policy months will be calculated from the Policy date. All periods of insurance thereunder will begin and end at 12:01 A.M. Standard Time at the Policyholder's place of business.

The Policyholder may renew the Policy for a further term of one (1) year, on the first and each successive anniversary of its effective date; provided, however, that the Insurance Company has the right to: (A) decline to renew the Policy on any anniversary, and (B) to decline to renew a particular insurance coverage on the first anniversary, or on any premium due date thereafter. If, in accordance with this paragraph, the Policy is not renewed, all Employer Riders shall thereupon terminate as of the date the Policy terminates. Subject to the foregoing, the renewability of the insurance provided under an Employer Rider shall be in accordance with the provisions of such Rider.

Renewal is conditioned upon payment of the premium then due, computed as provided in the Section entitled "Premium for the Policy".

6. Premium for the Policy

Premiums due under the Policy must be paid by the Policyholder at an office of the Guardian or to a representative that we have authorized. The premiums must be paid as specified on the first page of the Policy, unless by agreement between the Policyholder and the Guardian, the interval of payment is changed. In that event, adjustment will be made to provide for payment annually, semi- annually, quarterly or monthly.

The premium due under the Policy on each Policy due date will be the sum of the premium charges for the insurance coverages provided under the Policy. The premium charges are based upon the rates set forth in the Policy's "Schedule of Insurance and Premium Rates" section.

However, we may change such rates: (a) on the first day of any Policy month; (b) on any date the extent or terms of coverage for a Policyholder are changed by amendment of the Policy; or (c) on any date our obligation under the Policy with respect to a Policyholder is changed because of statutory or other regulatory requirements.

We must give the Policyholder 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

Welcome to the College Tuition Benefits Rewards program! Your Plan Sponsor has worked with Guardian to make College Tuition Benefit services available to eligible participants enrolling in the following coverage/option(s):

Coverage	Option
Dental	Option 1: PPO Option 2: PPO

Register Today!

You can now create your Rewards account and start accumulating your Tuition Rewards that can be used to pay up to one year's tuition at over 380 private colleges and universities across the nation. In 2016, over \$60 million in College Tuition Benefit Rewards were submitted by high school seniors. **Here is how it works:**

- Annual enrollment in this plan earns you 2,000 Tuition Rewards (1 Reward = \$1 in tuition reduction at a network of Private Colleges and Universities) for each line of Guardian coverage (up to four lines).
- Guardian Dental participants receive a bonus after year four.
- These rewards are yours for your lifetime and can be given to children, grandchildren, nieces, nephews and godchildren.

The Tuition Rewards program is provided by College Tuition Benefit. The Guardian Life Insurance Company of America (Guardian) does not provide any services related to this program. College Tuition Benefit is not a subsidiary or an affiliate of Guardian.

Print and cut out ID Card

College Tuition Benefits Rewards- ID Card	f o l d	The College Tuition Benefit 435 Devon Park Drive Building 400, Suite 410 Wayne, PA 19087 Phone: (215) 839-0119 Fax: (215) 392-3255
Register@ www.Guardian.CollegeTuitionBenefit.com User ID: Is Your Guardian Group Plan Number that can be found on your benefit booklet Password: Guardian		



Easy-To-Use Online Link Provides Faster Processing

Guardian's online electronic Evidence of Insurability (EOI) provides an alternative to paper EOI forms when you need to provide additional information for requested coverage.

Common situations include:

- Answering yes to one of the health questions on your enrollment form
- Enrolling for coverage in excess of the guaranteed issue amount
- Requesting coverage after your initial eligibility for coverage

Electronic Evidence of Insurability can be used for the following coverages*:

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

Guardian's online EOI form offers several advantages:

- Your personal data is kept secure
- No errors due to hand-written data
- Faster submission of your completed form

Accessing the electronic Evidence of Insurability link

Simply go to : guardiananytime.com/eoi

No registration is required. The process is easy and secure, simply follow the steps outlined below:

- 1 Fill in your Group ID #
- 2 Enter your personal information
- 3 Answer the health questions
- 4 Electronically sign your name and click 'Submit'

Guardian receives the completed EOI form in minutes!

- 1 Guardian's Medical Underwriting Team moves through the EOI process and will contact you with any questions.
- 2 We will send you a letter in the mail regarding the status of your request for coverage.
- 3 We will notify your employer of the outcome of your request only if your coverage amount is changed.

If you have questions about the process or if you need to provide evidence of insurability, please contact your Plan Administrator.

The Guardian Life Insurance Company of America
New York, NY

guardiananytime.com

*Applicable to coverage requiring full Evidence of Insurability (not applicable to conditional issue amounts). Electronic EOI is not available in New York and New Hampshire. Electronic EOI is available using most internet browsers.

Guardian® is a registered service mark of The Guardian Life Insurance Company of America.

WorkLifeMatters

Your Confidential Employee Assistance Program – Helping find balance between work and home life.

WorkLifeMatters provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

- **Unlimited free telephonic consultation with an EAP counselor available 24/7 at 800-386-7055**
- **Referrals to local counselors — up to three sessions free of charge**
- **State-of-the-art website featuring over 3,400 helpful articles on topics like wellness, training courses, and a legal and financial center**

WorkLifeMatters can offer help with:

Education

- Admissions testing & procedures
- Adult re-entry programs
- College Planning
- Financial aid resources
- Finding a pre-school

Lifestyle & Fitness Management

- Anxiety & depression
- Divorce & separation
- Drugs & alcohol

Dependent Care & Care Giving

- Adoption Assistance
- Before/after school programs
- Day Care/Elder Care
- Elder care
- In-home services

Working Smarter

- Career development
- Effective managing
- Relocation

Legal and financial

- Basic tax planning
- Credit & collections
- Debt Counseling
- Home buying
- Immigration

For more information about WorkLifeMatters, go to www.ibhworklife.com; User Name: Matters; Password: wlm70101

WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters Program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters Program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.

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

Please print clearly and mark carefully.

Employer Name: ESSEX PORTFOLIO, L.P.	Group Plan Number: 00477073/00511190 Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Re-Enrollment <input type="checkbox"/> Add Employee/Dependents <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change <input type="checkbox"/> Increase Amount <input type="checkbox"/> Family Status Change	

Class: ALL ELIGIBLE EXECUTIVES NOT LOCATED IN CALIFORNIA Division: _____ Subtotal Code: _____ (Please obtain this from your Employer)

About You: First, MI, Last Name:		Social Security Number ____ - ____ - ____	
Address	City	State	Zip
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yy): ____ - ____ - ____	Phone: () -	
Email Address:	Are you married or do you have a spouse/domestic partner? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage/union: ____ - ____ - ____	
	Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placement date of adopted child: ____ - ____ - ____	

About Your Job:	Hours worked per week: _____	Job Title:
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> 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/domestic partner (First, MI, Last Name)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____	Date of Birth (mm-dd-yyyy) ____ - ____ - ____
Address/City/State/Zip:			
Phone: () -			
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ____ - ____ - ____
Phone: () -			Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____
Address/City/State/Zip:			Date of Birth (mm-dd-yyyy) ____ - ____ - ____
Phone: () -			Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

Child/Dependent 3: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

Drop Coverage: <input type="checkbox"/> Drop Employee <input type="checkbox"/> Drop Dependents The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage: ____ - ____ - ____ <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement Last Day Worked: ____ - ____ - ____ <input type="checkbox"/> Other Event: _____ Date of Event: ____ - ____ - ____	Coverage Being Dropped: <input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Child(ren) <input type="checkbox"/> Basic Life <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Child(ren) <input type="checkbox"/> Long Term Disability
Loss Of Other Coverage: I and/or my dependents were previously covered under <u>another insurance plan</u> . Loss of coverage was due to: <input type="checkbox"/> Termination of Employment: ____ - ____ - ____ <input type="checkbox"/> Divorce ____ - ____ - ____ <input type="checkbox"/> Death of Spouse/domestic partner ____ - ____ - ____ <input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____ Coverage Lost <input type="checkbox"/> Dental	I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____ (additional information may be required)

Dental Coverage: You must be enrolled to cover your dependents. Check only one box.

	Employee Only	EE, Spouse/domestic partner & Dependent/Child(ren)
Option 1: PPO	<input type="checkbox"/>	<input type="checkbox"/>
Option 2: PPO	<input type="checkbox"/>	<input type="checkbox"/>

I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:

- I am covered under another Dental plan
- My spouse/domestic partner is covered under another Dental plan
- My dependents are covered under another Dental plan

Basic Life Coverage:

Benefit reductions apply. Please see plan administrator.

Policy Amount
Employee Only
 200% of your annual salary to a maximum of \$500,000
The Guarantee Issue Amount is \$500,000.

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.)

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

Important Notes:

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

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

- | | | | | | |
|-------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$30,000 | <input type="checkbox"/> \$40,000 | <input type="checkbox"/> \$50,000 | <input type="checkbox"/> \$60,000 | <input type="checkbox"/> \$70,000 |
| <input type="checkbox"/> \$80,000 | <input type="checkbox"/> \$90,000 | <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$110,000 | <input type="checkbox"/> \$120,000 | <input type="checkbox"/> \$130,000 |
| <input type="checkbox"/> \$140,000 | <input type="checkbox"/> \$150,000 | <input type="checkbox"/> \$160,000 | <input type="checkbox"/> \$170,000 | <input type="checkbox"/> \$180,000 | <input type="checkbox"/> \$190,000 |
| <input type="checkbox"/> \$200,000* | <input type="checkbox"/> \$210,000 | <input type="checkbox"/> \$220,000 | <input type="checkbox"/> \$230,000 | <input type="checkbox"/> \$240,000 | <input type="checkbox"/> \$250,000 |
| <input type="checkbox"/> \$260,000 | <input type="checkbox"/> \$270,000 | <input type="checkbox"/> \$280,000 | <input type="checkbox"/> \$290,000 | <input type="checkbox"/> \$300,000 | <input type="checkbox"/> \$310,000 |
| <input type="checkbox"/> \$320,000 | <input type="checkbox"/> \$330,000 | <input type="checkbox"/> \$340,000 | <input type="checkbox"/> \$350,000 | <input type="checkbox"/> \$360,000 | <input type="checkbox"/> \$370,000 |
| <input type="checkbox"/> \$380,000 | <input type="checkbox"/> \$390,000 | <input type="checkbox"/> \$400,000 | <input type="checkbox"/> \$410,000 | <input type="checkbox"/> \$420,000 | <input type="checkbox"/> \$430,000 |
| <input type="checkbox"/> \$440,000 | <input type="checkbox"/> \$450,000 | <input type="checkbox"/> \$460,000 | <input type="checkbox"/> \$470,000 | <input type="checkbox"/> \$480,000 | <input type="checkbox"/> \$490,000 |
| <input type="checkbox"/> \$500,000 | | | | | |
- \$ _____

*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/domestic partner

Policy Amount

- | | | | | | |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$12,000 | <input type="checkbox"/> \$15,000 | <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$25,000 | <input type="checkbox"/> \$30,000 |
| <input type="checkbox"/> \$35,000 | <input type="checkbox"/> \$40,000 | <input type="checkbox"/> \$45,000 | <input type="checkbox"/> \$50,000* | <input type="checkbox"/> \$55,000 | <input type="checkbox"/> \$60,000 |
| <input type="checkbox"/> \$65,000 | <input type="checkbox"/> \$70,000 | <input type="checkbox"/> \$75,000 | <input type="checkbox"/> \$80,000 | <input type="checkbox"/> \$85,000 | <input type="checkbox"/> \$90,000 |
| <input type="checkbox"/> \$95,000 | <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$105,000 | <input type="checkbox"/> \$110,000 | <input type="checkbox"/> \$115,000 | <input type="checkbox"/> \$125,000 |
| <input type="checkbox"/> \$130,000 | <input type="checkbox"/> \$135,000 | <input type="checkbox"/> \$140,000 | <input type="checkbox"/> \$145,000 | <input type="checkbox"/> \$150,000 | <input type="checkbox"/> \$155,000 |
| <input type="checkbox"/> \$160,000 | <input type="checkbox"/> \$165,000 | <input type="checkbox"/> \$170,000 | <input type="checkbox"/> \$175,000 | <input type="checkbox"/> \$180,000 | <input type="checkbox"/> \$185,000 |
| <input type="checkbox"/> \$190,000 | <input type="checkbox"/> \$195,000 | <input type="checkbox"/> \$200,000 | <input type="checkbox"/> \$205,000 | <input type="checkbox"/> \$210,000 | <input type="checkbox"/> \$215,000 |
| <input type="checkbox"/> \$220,000 | <input type="checkbox"/> \$225,000 | <input type="checkbox"/> \$230,000 | <input type="checkbox"/> \$235,000 | <input type="checkbox"/> \$240,000 | <input type="checkbox"/> \$245,000 |
| <input type="checkbox"/> \$250,000 | | | | | |

*Guarantee Issue Amount

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

I do not want this coverage

LIFE INSURANCE *continued*

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 50% 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.)

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

Long-Term Disability (LTD) Coverage:

Monthly Benefit

- 60% of salary to a maximum of \$15,000

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 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.
- "California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."

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.

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 hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

California law requires that insurers offering Accident, Cancer, Critical Illness and Hospital Indemnity policies or certificates must require that the person to be insured is covered for essential health benefits or minimum essential coverage as defined in federal law. If you do not have such essential health benefits or minimum essential coverage as defined in federal law, you may not enroll for Accident, Cancer, Critical Illness or Hospital Indemnity Coverage. By your signature below, you affirmatively attest that you, and any dependents to be covered, are covered by essential health benefits or minimum essential coverage as defined in federal law.

SIGNATURE OF EMPLOYEE X _____

DATE _____

Enrollment Kit 00477073, 0002, EN

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.

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 York: 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.)

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of 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.