

GROUP BENEFITS

GUARDIAN OF GEORGIA DBA ACKERMAN SECURITY SYSTEMS

Benefits Enrollment Form



Information About You

Name:	37425-0	Social Security Number / Employee ID Number:
Date of Birth:		Date of Hire:
Earnings:		Location/Department/Division:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please enter or check your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer's contract.*
- **Step 2:** Please sign, date and return this form to Human Resources.

Voluntary Long Term Disability Insurance

You have the opportunity to enroll in Voluntary Long Term Disability Insurance. Voluntary Long Term Disability Insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been Disabled for a predetermined waiting period, known as the elimination period, of 180 days. This plan provides you with income protection to replace up to 60% of your Earnings, to a maximum monthly benefit of \$5,000. If you enroll during this enrollment period, your coverage is provided to you on a guaranteed issue basis – no medical information is required. If you enroll after this enrollment period, evidence of insurability will be required for all coverage amounts.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.1210	0.1050	0.2490	0.3490	0.3890	0.6300	0.8560	1.0040	0.8350	0.6390	0.6390	0.6390

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Your Annual Earnings}}{\text{Maximum} = \$100,000} \div 12 = \frac{\text{Your Monthly Earnings}}{\text{Earnings}} \div 100 = \text{Rate} \times \text{Rate} = \$ \text{My Monthly Cost}$$

- ☐ I elect to **purchase** Long Term Disability coverage.
- ☐ I **decline** to purchase Long Term Disability coverage.

Voluntary Short Term Disability Insurance

You have the opportunity to enroll in Voluntary Short Term Disability Insurance. Voluntary Short Term Disability Insurance helps to replace your income if you are sick or injured and cannot work. This coverage begins on the 8th day of accident and 8th day of illness and is designed to continue for a period of 25 weeks and provides income protection to replace up to 60% of your Earnings, to a maximum weekly benefit of \$1,000. If you enroll during this enrollment period, your coverage is provided to you on a guaranteed issue basis – no medical information is required. If you enroll after this enrollment period, evidence of insurability will be required for all coverage amounts.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.8500	0.9000	0.8200	0.6800	0.7400	0.7800	0.9000	1.2300	1.6500	1.7800	1.7800	1.7800

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Your Annual Earnings}}{\text{Earnings}} \div 52 = \frac{\text{Your Weekly Earnings}}{\text{Earnings}} \times 60\% = \frac{\text{Weekly Benefit Max} = \$1,000}{\text{Benefit}} \div 10 = \text{Rate} \times \text{Rate} = \$ \text{My Monthly Cost}$$

- ☐ I elect to **purchase** Short Term Disability coverage.
- ☐ I **decline** to purchase Short Term Disability coverage.

Basic Life and AD&D Insurance

GUARDIAN OF GEORGIA DBA ACKERMAN SECURITY SYSTEMS provides, at no cost to you, Basic Life and AD&D Insurance in an amount

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GUARDIAN OF GEORGIA DBA ACKERMAN SECURITY SYSTEMS
Generic Newly Eligible Full Language

**Prepare Today.
Help Protect Tomorrow.**

Name: _____

equal to \$20,000.

Supplemental Life Insurance

You can purchase Supplemental Life Insurance in increments of \$10,000. The maximum amount you can purchase cannot be more than 5 times your annual Earnings or \$500,000. If you elect an amount that exceeds the guaranteed issue amount of \$50,000, you will need to provide evidence of good health that is satisfactory to The Hartford before the excess can become effective.

Have you smoked a cigarette, cigar, used pipe or chewing tobacco, nicotine chewing gum or snuff during the 12 months prior to today's date? If YES, use The Tobacco User cost below; if No, use the Non Tobacco User cost below:

☐ Yes ☐ No

Non Tobacco User

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.1100	0.1100	0.1150	0.1510	0.2100	0.3320	0.5120	0.8420	1.2710	2.2080	3.9380	7.9250

Tobacco User

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.1630	0.1630	0.1720	0.2430	0.3700	0.5800	0.9850	1.3990	1.9790	3.2750	5.6880	10.2250

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Life Benefit Amount}}{\div \$1,000} = \text{_____} \times \text{Rate} = \$ \text{_____} \text{ My Monthly Cost}$$

☐ I elect to **purchase** \$_____ of Life coverage.

☐ I **decline** to purchase Life coverage.

Spouse Supplemental Life Insurance

If you purchase Supplemental Life Insurance, you can purchase Spouse Supplemental Life Insurance in increments of \$5,000. The maximum amount you can purchase cannot be more than the lesser of \$250,000 or 100% of your Employee Voluntary/Supplemental Life Insurance coverage. If you elect an amount that exceeds the guaranteed issue amount of \$25,000, your Spouse will need to provide evidence of good health that is satisfactory to The Hartford before the excess can become effective.

Costs are based on Employee's age.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.1080	0.1080	0.1140	0.1560	0.2240	0.3480	0.5480	0.8360	1.4500	2.4540	4.3220	8.5760

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Life Benefit Amount}}{\div \$1,000} = \text{_____} \times \text{Rate} = \$ \text{_____} \text{ My Monthly Cost}$$

☐ I elect to **purchase** \$_____ of Life coverage.

☐ I **decline** to purchase Life coverage.

First Name	Last Name	Gender	Date of Birth	Date of Marriage

Child(ren) Supplemental Life Insurance

If you purchase Supplemental Life Insurance, you can purchase Child(ren) Supplemental Life Insurance for your Dependent Child(ren) between the ages of 15 days and 19 years (26 years if a full time student), in the amount(s) of \$10,000. Child(ren) between the ages of 15 days and 6 months are limited to coverage in the amount of \$1,000.

☐ I elect to **purchase** \$10,000 of Life coverage at a Monthly cost of \$2.70 (cost is for all covered Children).

☐ I **decline** to purchase Life coverage.

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Name: _____

First Name	Last Name	Date of Birth	Gender

Family Voluntary Accidental Death & Dismemberment Insurance

You can purchase Family Voluntary Accidental Death & Dismemberment Insurance in increments of \$10,000. The maximum amount you can purchase cannot be more than the lesser of 5 times your annual Earnings or \$500,000.

You can also purchase coverage for your Spouse or Child(ren) at the percentages of your election outlined in the following chart:

Family Member(s) Covered:	Employee Only	Employee & Spouse Only	Employee & Child(ren) Only	Employee, Spouse & Child(ren)
Percent of Benefit Paid:	100%	100% for Employee 50% for Spouse	100% for Employee 15% for each Child	100% for Employee 40% for Spouse 10% for each Child

Coverage Option:	Rate
Myself Only	\$0.0500
Myself and My Family	\$0.0680

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Elected Benefit Amount (Employee Coverage Amount Only)}}{\div \$1,000} = \text{_____} \times \text{Rate} = \$ \text{My Monthly Cost}$$

- ☐ I elect to purchase \$_____ of AD&D coverage for myself only.
- ☐ I elect to purchase \$_____ of AD&D coverage for myself. My family will be covered at the percentages of my election listed above.
- ☐ I decline to purchase AD&D coverage.

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

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Name: _____

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your spouse and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Disclaimer: Spousal consent does not apply to ERISA plans.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ Date: _____

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life, Disability, and Accident Insurance coverage described in the Benefit Highlight Sheets and offered through GUARDIAN OF GEORGIA DBA ACKERMAN SECURITY SYSTEMS.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____

**Please print, sign, then scan
and submit an electric copy or
hand deliver to HR.**

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