



Employer:
Oral Roberts University
 7777 South Lewis
 Tulsa, OK 74171

Guardian Group Plan Number: **418957**

The Guardian Life Insurance Company of America

The Guardian Insurance & Annuity Company, Inc.,
 A wholly owned subsidiary of Guardian

EMPLOYER USE ONLY <input type="checkbox"/> New Application <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Drop Dependent(s) <input type="checkbox"/> Annual Re-enrollment <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name <input type="checkbox"/> Drop Coverage as of: / /			
Class All Other Eligible Employees	Hours Worked	Division	Benefits Effective / /
Keep a copy for your records and return form to: Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012			

ABOUT YOURSELF <i>Print clearly in black or blue ink.</i>			
First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -
Address	City	State	Zip
Preferred E-mail	Day Phone	Eve Phone	The best way to reach you: <input type="checkbox"/> E-mail <input type="checkbox"/> Day Phone <input type="checkbox"/> Eve Phone
Job Title	Work Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation	Date work status began / /	Annual Salary/Earnings \$
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	

ABOUT YOUR DEPENDENTS <input type="checkbox"/> A sheet with information about additional dependents is attached.					
Spouse First, Middle Initial, Last Name <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Marriage Date (mm/dd/yyyy) / /	
Child 1 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
State of Residence:					
Child 2 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
State of Residence:					
Child 3 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
State of Residence:					
Child 4 <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Drop	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yyyy) / /	<input type="checkbox"/> Full-time student, at (school):	City/State:	Attending Since / /
State of Residence:					
To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages. <input type="checkbox"/> Basic Life <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Dental <input type="checkbox"/> VAD&D					

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

YOUR BASIC LIFE COVERAGE

Employee	Policy Amount <input checked="" type="checkbox"/> 100% of your annual salary to maximum \$50,000
----------	------------------------------------------------------------------------------------------------------------

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

Name your beneficiaries		Primary beneficiaries must total 100%.
Primary Beneficiary 1 First, Middle Initial, Last Name	Relationship to Employee	Percent
Primary Beneficiary 2		%
Contingent Beneficiary		%

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

CHOOSE YOUR VOLUNTARY TERM LIFE COVERAGE

Check one box only

Employee	Policy Amount <input type="checkbox"/> 1 times salary <input type="checkbox"/> 2 times salary <input type="checkbox"/> 3 times salary You may select a multiple of your salary to a maximum of \$400,000	You must be enrolled to cover your dependents.
<input type="checkbox"/> I waive this coverage		

Add Voluntary Life for Spouse	<i>Check one box only</i>
<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000* <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"/> \$200,000 \$ _____ *Guarantee Issue Amount	
<input type="checkbox"/> I waive this coverage <i>The amount may not be more than 50% of the employee amount for Voluntary Life.</i>	

Add Voluntary Life for Child(ren)	<i>Check one box only</i>
<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$8,000 <input type="checkbox"/> \$10,000* \$ _____ *Guarantee Issue Amount	
<input type="checkbox"/> I waive this coverage <i>The amount may not be more than 10% of the employee amount for Voluntary Life.</i>	

CHOOSE YOUR ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

Check one box only

Employee	Policy Amount <input type="checkbox"/> \$10,000 <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"/> \$250,000 <input type="checkbox"/> \$500,000	You must be enrolled to cover your dependents.
<input type="checkbox"/> I waive this coverage		

Add Voluntary AD&D for Spouse	<i>Check one box only</i>
<input type="checkbox"/> 50% of employee's amount to maximum \$250,000	
<input type="checkbox"/> I waive this coverage <i>The amount may not be more than 50% of the employee amount for Voluntary Accidental Death & Dismemberment</i>	

Add Voluntary AD&D for Child(ren)	<i>Check one box only</i>
<input type="checkbox"/> 10% of employee's amount to maximum \$10,000	
<input type="checkbox"/> I waive this coverage <i>The amount may not be more than 10% of the employee amount for Voluntary Accidental Death & Dismemberment</i>	

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

IMPORTANT NOTES

- If you waive life or disability coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian reserves the right to reject your request.
- Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Voluntary Life and/or Guardian Universal Life.

CHOOSE YOUR SHORT-TERM DISABILITY (STD) COVERAGE	
30/30 Plan	8/8 Plan
<i>Weekly Benefit</i>	
<input type="checkbox"/> 60% of salary to a maximum of \$1,500	<input type="checkbox"/> 60% of salary to a maximum of \$1,500
<input type="checkbox"/> I waive this coverage.	

CHOOSE YOUR LONG-TERM DISABILITY (LTD) COVERAGE
<i>Monthly Benefit</i>
<input checked="" type="checkbox"/> 60% of salary to a maximum of \$7,000

IMPORTANT NOTES

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

CHOOSE YOUR DENTAL COVERAGE			<i>Check one box only</i>
	Option 1: Base Plan	Option 2: Buy-Up Plan	
Employee alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I waive this coverage
Employee and 1 Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I waive this coverage
Entire family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> I waive this coverage
If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.			
Reason for Loss of coverage: <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Spouse <input type="checkbox"/> Termination or Expiration of coverage			Date of coverage loss / /
If you are waiving coverage, are you covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you are waiving dependent coverage, are your dependents covered under another dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

IMPORTANT NOTES

- Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.
- Vision Discount Access is included with your dental plan at no charge. You must elect dental in order to qualify for Vision Discount Access.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

SIGNATURE

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I understand that I must be actively at work or my life and/or disability coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- I acknowledge and agree that Guardian may provide me information concerning benefits, including explanation of benefit statements and other claims related information solely in electronic format as permitted by law. I may change this election only by providing Guardian thirty (30) day prior written notice.
- I understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
- I attest that the information provided above is true and correct to the best of my knowledge.
- **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.**

SIGNATURE OF EMPLOYEE X

DATE

3/18

