Planholder Name	Group Plan #	Date / /
Planholder Address		Member ID

Name of Insured Employee (Last, First, MI)	☐ M ☐ F	Social Security #	Date of Birth / /	Class

Names of Continuing Eligible Dependents (If more space is needed please attach a separate sheet of paper)

Full Name (Last, First, MI)	Social Security #	Sex	Date of Birth	Relationship to Employee
		☐ M ☐ F	/ /	
		☐ M ☐ F	/ /	
		☐ M ☐ F	/ /	
		☐ M ☐ F	/ /	

Home Address:

Reason for Loss of Coverage *(Check one)*

☐ Termination of Employment ☐ Legal Separation ☐ Child Losing Dependent Status
☐ Reduction of Work Hours ☐ Divorce ☐ Death of Employee

Date Coverage Will Terminate Due to Qualifying Event / /

For Guardian Use Only

Explanation *(If necessary)*

This notice contains important information about your right to continue your Guardian group dental and/or vision coverage. It also advises you that other health coverage alternatives may be available to you through your state's Health Insurance Marketplace. Please read the information contained in this notice very carefully.

Federal law permits continuation of Guardian group dental and vision coverage for certain qualifying events. Each person ("qualified beneficiary") who has one of the qualifying events below is entitled to elect COBRA continuation coverage. This election will continue your group dental and/or vision coverage under the Plan for the period of time listed in the corresponding coverage period. An individual's Life, Accidental Death and Dismemberment, and Short Term or Long Term Disability coverage may not be continued.

There may be other coverage options for you and your family. With the opening of the individual health care exchanges, you are able to buy coverage through your state's Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Qualifying Events	Qualified Beneficiary	Coverage Period
Termination (other than gross misconduct)	Employee, Spouse, Dependent Child	18 months
Reduced Hours	Employee, Spouse, Dependent Child	18 months
Employee Enrolled in Medicare	Spouse, Dependent Child	36 months
Divorce or legal separation	Spouse, Dependent Child	36 months
Death of covered employee	Spouse, Dependent Child	36 months
Loss of "dependent child" status	Dependent Child	36 months

Note:
An individual who is determined to be totally disabled under the Social Security Act at any time during the first 60 days of continued coverage, or a family member of the individual, may extend coverage from 18 to 29 months if the determination is provided before the end of the 18 month period. When it is determined under the Social Security Act that the individual is no longer disabled, continuation beyond 18 months will end in the month that begins more than 30 days after the determination.

COBRA continuation will cost: $_____. You do not have to send any payment with this Election Form. Important additional information about payment for COBRA continuation coverage is included in a packet of information, which is included in the pages following this election form.

NOTE: This is an election form only. It is not intended to constitute complete notice of your COBRA continuation rights. If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact your employer/plan administrator.

Instructions:

To elect COBRA continuation coverage, complete this Election Form and return it to your employer/plan administrator. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan. This election form must be completed and returned to your employer/plan administrator within 60 days of notification.

If you do not submit a completed Election Form to your employer/plan administrator within 60 days of notification, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

PLEASE READ THE CERTIFICATE BOOKLET FOR ADDITIONAL INFORMATION

☐ I do not elect to continue my dental and/or vision coverage under the Group Plan.
☐ I elect to continue my dental and/or vision h t5 (c)-a5.3 (uatd 1.4 (o)15.2 (nt)qu.9 (o)11.3 (m)35.2 (nt).5 (.)]5.2 (nt)11.1 (al)0.9 (h t5 (c)-ou1.2 (al).9 (ec)4.8 (n o)e63.4v)-d 5.2 (ge,b5.3 (v)-0.(o)1

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IMPORTANT INFORMATION
ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who is not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment (if applicable) and/or special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows t

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact employer/plan administrator to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

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For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa