GUARDIAN

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

PO Box 14319
Lexington, KY 40512

GROUP TERM LIFE AND DISABILITY EVIDENCE OF INSURABILITY FORM

Please complete this form in ink. Erasures and changes invalidate this form.

Planholder Name (Company Name)	Group Plan No.
FXCM Global Services, LLC	480798

Complete the following information for each person to be underwritten:

Name (Last, First, Middle Initial)	Sex	Birthdate	Height	Weight	Full time Student
Employee: Iva Jurkovic	☐M ■F	07/25/85	5'7"	140	☐ Yes ■ No
Employee Home Address: 20 Newport Parkway, Apt 601		Preferred Method of Contact: Email		Employee Telephone Number: 312-929-9137	
Date of Hire: / /03/15/2013	Cell Phone: 312-929-9137	E-mail Address: iva.jurkovic@outlook.com			
Spouse: Juan Cafe	■M ☐F	Birthdate 12/16/81	Height 5'8"	Weight 205	■ Yes ☐ No
Child:	☐M ☐F	Birthdate	Height	Weight	☐ Yes ☐ No
Child:	☐M ☐F	Birthdate	Height	Weight	☐ Yes ☐ No

Employee's Social Security Number:	Date of Marriage:	Employee's Place of Birth (State):
687-54-6637	/ / 05/19/2017	Croatia
Employee Amount of Insurance Currently Inforce:	**Spouse Amount of Insurance Currently Inforce:**	**Child Amount of Insurance Currently Inforce:**
0	0	
Employee's Insurance Amount Elected:	**Spouse Insurance Amount Elected:**	**Child Insurance Amount Elected:**
150000	50000	

Section I: IF APPLYING FOR LIFE INSURANCE, questions 1-5 must be answered by each person applying for coverage to the best of the applicant's knowledge and beliefs. However, if applying for coverage for a child, the Employee must complete questions 1-5 for the child applying for coverage. IF APPLYING FOR DISABILITY INSURANCE, questions 1-5 must only be answered by the Employee.

1. In the past 10 years, has any proposed insured been treated for or diagnosed as having any of the following: a) any disorder or condition of the heart; liver, kidney(s); lung or respiratory system; b) any disorder or condition of your digestive system including your esophagus, stomach, or intestines; c) any mental, nervous, emotional or neurological disorder or condition; d) auto immune disorder; e) diabetes; f) cancer; or g) a stroke?;	Employee ☐ Yes ■ No Spouse ☐ Yes ■ No Child ☐ Yes ☐ No
2. In the past 5 years, has any proposed insured: used any illegal drugs; used prescription medication other than as prescribed; been treated for alcoholism or drug use or dependency; or been advised to seek treatment for alcoholism, drug abuse or drug dependency?	Employee ☐ Yes ■ No Spouse ☐ Yes ■ No Child ☐ Yes ☐ No
3. Has any proposed insured been treated for or diagnosed by a licensed member of the medical profession as having Human Immuno-deficiency Virus (HIV); Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	Employee ☐ Yes ■ No Spouse ☐ Yes ■ No Child ☐ Yes ☐ No
4. In the past year, has any proposed insured: (a) consulted or been examined by or treated by a physician, practitioner or specialist for any illness or injury, disease or disorder NOT listed in the questions above (including routine physicals only when there is an existing or newly diagnosed medical condition); or (b) sought treatment or a consultation in a hospital or other health care facility for observation, diagnosis, treatment or an operation; undergone any diagnostic testing including but not limited to X ray, blood work, ultrasound, an MRI, a CT scan, or PET scan with abnormal findings; or been prescribed medication(s) – (other than for colds, flu or allergies)?	Employee ☐ Yes ■ No Spouse ☐ Yes ■ No Child ☐ Yes ☐ No
5. **If applying for disability coverage, please complete these additional questions:** (a) In the past 5 years, has any proposed insured been treated for any disorder or condition of the back, neck, spine; arthritis; or any muscular skeletal disorder or condition? (b) Are you currently pregnant?	Employee ☐ Yes ☐ No Employee ☐ Yes ☐ No

Please retain a copy for your records and submit this form to Guardian

For each "yes" answer to question 1 through 5 give details below. (Continue on reverse side if additional space is needed.)					
Question #	Name	Test, Injury, Illness, Disease, Operation or Complication	Date of Onset	Date of Recovery	Full Details (including Doctors' Names and Addresses)

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Representations of the Proposed Insured(s) and Authorization Please read and sign below.

Part I. Representations of the Proposed Insured

Those parties who sign below hereby represent that the statements and answers to the question(s) are, to the best of the knowledge and belief of the party signing below, full, complete, true and correctly recorded. Those parties who sign below understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required. When used in this Part I, "I" refers to the person applying for insurance signing below.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (except in the case of a late entrant, it is not at the Company's expense), that any proposed insured be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted, approved by the Company and the required premiums are received by the Company; and: (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I become insured on the date I do return to work and satisfy a waiting period (as defined in the Group Plan) of full-time service; (3) coverage for my dependents will not take effect if a dependent other than a newborn is: (a) confined to the hospital or other health care facility; or (b) is unable to perform the normal activities of someone of like age and sex; (4) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (5) the employer is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company. In the event the Company receives premiums in excess of the appropriate amount for the coverage provided, the Company will only be liable for the overpaid premiums plus applicable interest.

For Life Insurance Coverage Only: Material misrepresentations made by the insured relating to that person's insurability may be used in contesting the validity of the individual coverage with respect to which such statement was made within the first two years coverage issued based on this Evidence of Insurability Form is in effect, only if the statement is in a signed writing that is furnished to the insured or the insured's beneficiary.

For Coverages Other Than Life Insurance: Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may lead to rescission of any coverage issued based on this Evidence of Insurability Form.

Part II. Authorization to Obtain Information (Medical Records and other information)

I authorize my physician, medical practitioner, hospital, clinic, other health facility, practitioner, mental health professional, pharmacy or pharmacy benefit manager, laboratory, the MIB, Inc., insurance or reinsurance company, group policyholder, benefit plan administrator, employer, other organization, institution or person that has any records or knowledge of the Proposed Insured or his/her health, business associate, other person or organization to release any and all medical and non-medical information in its possession about me, to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, pharmaceutical history, and all past and present physical, mental condition, or treatment of me. Non-medical information includes employment history, job duties, and any wage or earnings information. I understand that the information released could contain reference to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric, and psychological conditions. I understand that medical and non-medical information that can be released does not include drug and alcohol records and psychotherapy notes. I understand that a separate authorization is required for these types of medical records.

I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may fully authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule). **By my signature below, I authorize** The Guardian Life Insurance Company of America or its reinsurers to make a brief report of my protected health information to MIB, Inc.

I know that I may revoke this authorization in writing, at any time, by sending a written request for revocation to the Guardian Corporate Secretary at 7 Hanover Square, New York, NY 10004-2616. I understand that a revocation is not effective to the extent that the Company and/or any of the entities listed above has already relied on this authorization, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I know that I may request and receive a copy of this authorization.

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I know that I may request and receive a copy of this authorization.

I agree that a photocopy of this authorization will be as valid as the original. I agree that this authorization will be valid for twenty four months from the date shown below.

By my signature below,

1. I agree with all of the terms, conditions, statements, and representations stated above in Part I. Representations of the Proposed Insured; and

2. I agree and consent to the Company obtaining and disclosing the information as stated above in Part II. Authorization to Obtain Information (Medical Records and Other Information) and with all other terms and conditions stated therein.

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. **(Does not apply to Life Insurance.)**

The state in which you reside may have a specific state fraud warning. Please refer to the Fraud Warning Statements page below.

The laws of New York require the following statement appear: 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.)

Ira Jurcovic

Signature of Employee — Nov 30, 2018 — Date

Signature of Spouse — Nov 30, 2018 — Date

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Insurance Information Practices Please read and detach for your records

Thank you for choosing The Guardian Life Insurance Company of America ("Guardian"). This notice is given to you at the time you apply for life or disability insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential, except as authorized by you, or as required by law. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to: The Privacy Office, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-4025.

MIB, Inc. Pre-Notice: Information regarding your insurability will be treated as confidential. Guardian, or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. member company for life, health or disability insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc., at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the information in your MIB, Inc. file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc., information office is 50 Braintree Hill Park, Suite 400, Braintree MA 02184-8734.

Guardian, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, health, or disability insurance, or to whom a claim for benefits may be submitted.

Medical Records: We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

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Fraud Warning Statements

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

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

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

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

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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, Kansas, Nebraska, Oregon, and Vermont: 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 the 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.

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.

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

Maine, Tennessee, Virginia 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 benefit.

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.

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.

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.

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.

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