GUARDIAN®

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

Please print clearly and mark carefully.

Employer Name: **FXCM Global Services, LLC**	Group Plan Number: **00480798**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX ❑ Initial Enrollment ☒ Re-Enrollment ❑ Add Employee/Dependents ❑ Drop/Refuse Coverage ❑ Information Change ❑ Increase Amount ❑ Family Status Change

[redacted]

About You:

First, MI, Last Name: Iva Jurkovic		Social Security Number 687546637- __ __ __ __	
Address: 20 Newport Parkway, Apt 601	City: Jersey City	State: NJ	Zip: 07310
Gender: ☐ M ☑ F	Date of Birth (mm-dd-yy): 07-25-85	Phone: (3129299137	
Email Address: iva.jurkovic@outlook.	Are you married or do you have a spouse? ☑ Yes ☐ No Do you have children or other dependents? ☐ Yes ☑ No	Date of marriage/union: 05-19-2017 -_____ Placement date of adopted child: ____-____-_____	

[redacted]

About Your Family: **Please include the names of the dependents you wish to enroll for coverage. A dependent is a person who relies on you for financial support. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.**

Spouse (First, MI, Last Name) Juan Cafe Address/City/State/Zip: Phone: ( ) -		Gender ☑ M ☐ F	Social Security Number 593 - 95 - 1922 Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	☐ Add ☐ Drop	Gender ☐ M ☐ F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ☐ Student (post high school) ☐ Disabled ☐ Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Nov 12, 2015

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

LIFE INSURANCE *continued*

Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life,

[redacted]

Specified Disease Coverage: **You must be enrolled to cover your dependents**

YOU MUST HAVE AT LEAST MAJOR MEDICAL INSURANCE OR AT LEAST BASIC HOSPITAL INSURANCE AND BASIC MEDICAL INSURANCE ON THE DATE OF THIS APPLICATION FOR SPECIFIED DISEASE COVERAGE. YOUR SIGNATURE AT THE END OF THIS FORM STATES THAT SUCH COVERAGE IS INFORCE ON SUCH DATE.

Benefit reductions apply. Please see plan administrator.

Employee
Insurance Amount: ☐ $5,000 ☐ $10,000 ☐ $15,000 ☑ $20,000 ☐ $25,000
☐ I do not want this coverage.

Spouse
Insurance Amount: ☑ 50% of the employee's amount
☐ I do not want this coverage.

Dependent/Child(ren)
Insurance Amount: ☐ 50% of the employee's amount
☑ I do not want this coverage.

Do you have on the date of this application, at least major medical insurance or at least basic hospital insurance and basic medical insurance (required underlying coverage) in force for yourself and any dependents being enrolled? Employee ☑ Yes. ☐ No. Spouse ☐ Yes. ☐ No.

If yes, proceed to the next section. If you do not have such coverage, a certificate will not be issued.

Do you have on the date of this application, other specified disease coverage in force (or pending applications) for the same disease(s) for which you are applying for coverage herein for yourself and any dependents being enrolled? ☑ Yes. ☐ No.

Please indicate the number of specified diseases for which you have coverage in force (or pending applications) for yourself and any dependents being enrolled.
Employee: 1 Dependents:_____

If you or your dependent spouse elect Specified Disease, you must answer the following health questions.

1. Has any proposed insured been diagnosed with or treated by a medical professional for any of the following conditions: cancer, carcinoma in situ,malignant melanoma, tumor (benign or malignant), Barrett's esophagus, Crohn's disease, ulcerative colitis, blood disorder (other than AIDS or HIV), any chronic or progressive disease of kidneys, liver (including hepatitis), lungs, including emphysema and COPD, pancreas or bone marrow? Or, been advised to have an organ transplant, including bone marrow or stem cell transplant?

Employee ☐ Yes ☑ No Spouse ☐ Yes ☐ No

2. Has any proposed insured been diagnosed with or treated by a medical professional for heart attack, heart disease or coronary artery disease, stroke or transient ischemic attack (TIA), or been advised to have bypass surgery, stent insertions or treatment for coronary arteries?

Employee ☐ Yes ☑ No Spouse ☐ Yes ☐ No

3. Has any proposed insured been diagnosed with or treated by a medical professional for uncontrolled blood pressure (requiring a change in medication or dosage in the past 6 months or been diagnosed with or treated for diabetes (except if present only in pregnancy)?

Employee ☐ Yes ☑ No Spouse ☐ Yes ☐ No

4. Has any proposed insured been diagnosed with or treated by a medical professional for AIDS (acquired immune deficiency syndrome) or AIDS-Related Complex?

Employee ☐ Yes ☑ No Spouse ☐ Yes ☐ No

IMPORTANT NOTES:

- Based on your plan benefits and age, you may be required to complete an additional evidence of insurability form for Specified Disease.
- No later than 30 days following delivery of specified disease coverage, Guardian will ask in a written request whether at least major medical insurance or at least basic hospital insurance and basic medical insurance (required underlying coverage) is in force on the effective date of the specified disease coverage. If Guardian receives a written response that the required underlying coverage is not in force for an insured person on the effective date of the specified disease coverage, the specified disease coverage for that insured person will be voided from its beginning with a full premium refund for such person.

Accident Coverage

You must be enrolled to cover your dependents.

YOU MUST HAVE AT LEAST COMPREHENSIVE HOSPITAL, SURGICAL AND MEDICAL INSURANCE ON THE DATE OF THIS APPLICATION FOR ACCIDENT COVERAGE. YOUR SIGNATURE AT THE END OF THIS FORM STATES THAT SUCH COVERAGE IS INFORCE ON SUCH DATE.

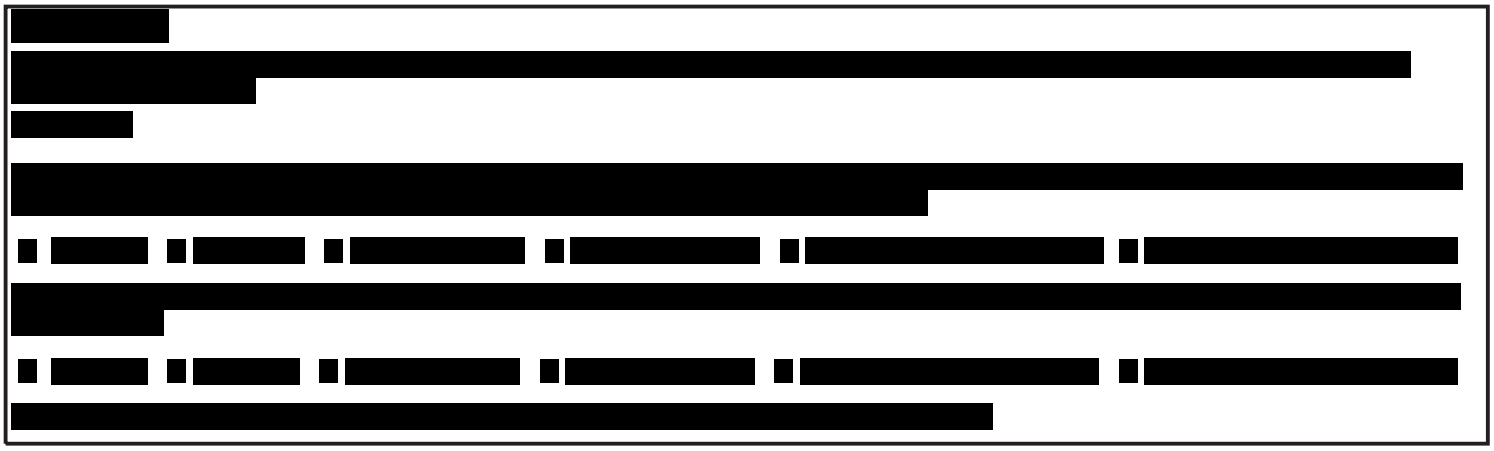
Do you have on the date of this application, at least comprehensive hospital, surgical and medical insurance (required underlying coverage) in force for yourself and any dependents being enrolled ? ☑ Yes ☐ No

If yes, proceed to the next section. If you do not have such coverage, a certificate will not be issued.

Your Semi-monthly premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: Value Plan	☑ $6.24	☐ $10.25	☐ $10.49	☐ $14.50
Option 2: Advantage Plan	☐ $8.56	☐ $13.98	☐ $14.11	☐ $19.52
Option 3: Premier Plan	☐ $10.92	☐ $17.79	☐ $17.60	☐ $24.47

❑ I do not want this coverage.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER



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.
- By signing this form, I state that I have at least major medical insurance or at least basic hospital insurance and basic medical insurance in force for Specified Disease and/or Accident coverage.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- 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.

Guardian Group Plan Number: **00480798** Please print employee name:

- I acknowledge and consent to receiving electronic copies of insurance related documents, in lieu of paper copies, to the extent permitted by applicable law ☒ I voluntarily agree to that arrangement. ❑ I do not agree to that arrangement. I understand that I may change my election by providing Guardian 30 day prior written notice.
- **I state that the information provided above is true and correct to the best of my knowledge.**

I understand that this is a supplemental accident-only policy and that it does not provide coverage for and is not intended to replace comprehensive hospital, surgical and medical insurance. I understand that this policy does not provide coverage for sickness. I acknowledge that I have comprehensive hospital, surgical and medical insurance. If you have questions about the benefits provided by this coverage, please contact us at 1-800-541-7846.

Any person who 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 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).

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. A discount is associated with the accelerated death benefits. A fee of up to $250.00 will be required for the administrative cost of evaluating and processing Your application for this benefit.

The Policy permits the group Policyholder to change, reduce, restrict or terminate Your rights or benefits under the Policy without Your consent; and b) such change, reduction, restriction or termination may occur at a time when Your health status has changed and may affect Your ability to procure individual coverage.
The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

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.)

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

Enrollment Kit 00480798, 0001, 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.

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 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.

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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 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.

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.