

SERFF Tracking Number: GARD-126265842 State: Arkansas  
 Filing Company: The Guardian Insurance & Annuity Company State Tracking Number: 43234  
 Inc.  
 Company Tracking Number:  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: 8292 GIAC  
 Project Name/Number: /

## Filing at a Glance

Company: The Guardian Insurance & Annuity Company Inc.

Product Name: 8292 GIAC

SERFF Tr Num: GARD-126265842 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 43234  
 Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Victoria Arama

Disposition Date: 08/18/2009

Date Submitted: 08/14/2009

Disposition Status: Approved-  
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 08/18/2009

Explanation for Other Group Market Type:

State Status Changed: 08/18/2009

Deemer Date:

Created By: Victoria Arama

Submitted By: Victoria Arama

Corresponding Filing Tracking Number:

Filing Description:

The captioned form is being submitted for filing and/or approval by your Department. The form will be used with our GP-GUL97 policy series currently on file with your Department.

Form CEF2009 is a group enrollment form that can be used for all group coverages offered by Guardian or a Guardian subsidiary. The form is substantially the same as CEF2005 that was approved by the Department on October 24, 2005. The changes include the addition of a Critical Illness enrollment section and expanded variability allowing for custom product naming options.

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The form is designed for maximum flexibility. It may be tailored on a case-by-case basis to reflect the benefits included in a particular employer's plan of group benefits. It may also be tailored to include requests for information for the parties to be insured. For example, references to "spouse", "child(ren)", and "dependents" would not be included if an employer's plan did not provide dependent coverage.

Variable material is outlined and numbered to correspond with the explanations in the attached memorandum.

The captioned form is being submitted in "final-print" format for filing purposes and is completed with hypothetical data in John Doe fashion. In actual use, it may be prepared on a case-by-case basis as explained above. We reserve the right to make small format changes in the form. However, we assure you that we will not modify text beyond the parameters specified at the time of the filing. This form may also be used for electronic enrollment system, or directly with Guardian.

The form in this submission was developed using simplified language. The form has a reading ease test score of at least 40. The form was computer-scored. The certification of readability scores required by your jurisdiction is attached.

Rates are not affected.

Form CEF2009 was filed and approved in the State of Delaware on January 22, 2009, the domiciliary state of The Guardian Insurance & Annuity Company, Inc.

A filing fee for the appropriate amount is being sent via EFT.

The above captioned form is being filed simultaneously with your Department for The Guardian Life Insurance Company of America.

Your early consideration of this submission is greatly appreciated.

## **Company and Contact**

### **Filing Contact Information**

Victoria Arama, State Filing Support  
Coordinator

7 Hanover Square 212-598-7971 [Phone]  
New York, NY 10004 212-919-3339 [FAX]

### **Filing Company Information**

The Guardian Insurance & Annuity Company CoCode: 78778 State of Domicile: Delaware  
Inc.

SERFF Tracking Number: GARD-126265842 State: Arkansas

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7 Hanover Square  
New York, NY 10004  
(212) 598-8000 ext. [Phone]

Group Code: 429  
Group Name:  
FEIN Number: 13-2656036

Company Type:  
State ID Number:

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? Yes  
Fee Explanation: \$50 x 1 = \$50.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Guardian Insurance & Annuity Company Inc.	\$50.00	08/14/2009	29858116

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	08/18/2009	08/18/2009

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## Disposition

Disposition Date: 08/18/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		No
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	Var. memo.		No
<b>Form</b>	Enrollment/Change Form		No

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## Form Schedule

Lead Form Number: CEF2009

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	CEF2009	Application/Enrollment/Change Enrollment Form Form	Initial		0.000	DOE_CEF2009_no maj med w dep bracket.pdf

**ENROLLMENT/CHANGE FORM**

1

Guardian Logo

2

The Guardian Life Insurance Company of America  
The Guardian Insurance & Annuity Company, Inc.

Guardian Group Plan Number:

Employer:

Plan Administrator:

3

**EMPLOYER USE ONLY**

New Enrollment.  Add Dependent(s).  Drop Dependent(s).  Annual Re-enrollment.  Increase amount.  
 Change Address.  Change Name.  Drop Coverage as of: (MM/DD/YR)

Class:

Hours Worked:

Division:

Payroll Period:

40/WK

FACTORY

B1-WEEKLY

4

Date Form Published:

Pay Periods Per Year:

Payroll Change Effective:

Benefits Effective:

Employer Contributions:

1/02/09

26

1/02/09

1/02/09

HealthCare Reimbursement FSA  
 Dependent Care FSA

Keep a copy for your records and return form to: Northeast Regional Office; P.O. Box 26040; Lehigh Valley, PA; 18002-6040 [or] Midwest Regional Office; P.O. Box 8012; Appleton, WI; 54912-8012 [or] Bridgewater Office; P.O. Box 425; E. Bridgewater, MA; 02333-0425 [or] Western Regional Office; P.O. Box 2454; Spokane, WA; 99210-2454 [or] Guardian Flex Plan; P.O. Box 26290; Leigh Valley PA; 18002-6290

**Employee**

Please provide this information about YOURSELF.

Please Print Clearly and in Black or Blue Ink.

Review the pre-filled information and make any needed corrections or additions below:

FIRST NAME: JON JOHN

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Drop First Name, Middle Initial, Last Name:

Sex:  M  F

Date of Birth (DOB): (MM/DD/YR)

Social Security Number:

JOHN Q. DOE

12/21/75

111-22-3333

Address 1:

Address 2:

City:

State:

Zip:

456 BOND DRIVE

ANYTOWN

NEW YORK

78901

Preferred Email:

Day Phone:

Eve Phone:

The best way to reach you:

N/A

555-667-7777

555-667-8888

Day Phone.  Eve Phone.  Email.

Job Title:

Work Status/Eligibility:

Full-Time.  Part-Time.  Retired.  COBRA/State Continuation.

Annual Salary/Earnings:

ASSEMBLER

Since (MM/DD/YR):

1/02/08

\$28,000.00

Are you married?  Yes.  No.

Do you have children or other dependents?  Yes.  No.

**DEPENDENTS**

Provide this information about your DEPENDENTS.

[ 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. ]

Drop Spouse/[Domestic Partner (DP)]  
First Name, Middle Initial, Last Name:

Sex:  M  F

DOB: (MM/DD/YR)

Social Security Number:

Date of Marriage: (MM/DD/YR)

MARY E. DOE

02/20/78

444-55-6677

06/06/99

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Drop Child 1:

Sex:  M  F

DOB: (MM/DD/YR)

Social Security Number:

Full-Time Student, at (school, city, state):

JOHN A. DOE  
[State of Residence:]

11/15/01

Since (MM/DD/YR):

<input type="checkbox"/> Drop	Child 2:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: (MM/DD/YR)	Social Security Number:	<input type="checkbox"/> Full-Time Student, at (school, city, state):
	[State of Residence:]				Since (MM/DD/YR): ]
<input type="checkbox"/> Drop	Child 3:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: (MM/DD/YR)	Social Security Number:	<input type="checkbox"/> Full-Time Student, at (school, city, state):
	[State of Residence:]				Since (MM/DD/YR): ]
<input type="checkbox"/> Drop	Child 4:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: (MM/DD/YR)	Social Security Number:	<input type="checkbox"/> Full-Time Student, at (school, city, state):
	[State of Residence:]				Since (MM/DD/YR): ]

A sheet with information about additional dependents is attached.

To drop coverage for yourself or your dependents, check the box(es) to the left of the name(s) and select the coverage(s) to drop. Attach a separate sheet if you wish to drop more than one dependent from different coverages.  Basic Life  Voluntary Life  Guardian Universal Life  AD&D

Long Term Disability  Short Term Disability  Dental  Vision  Flex Plan  Critical Illness

**LIFE INSURANCE**  
Choose your Basic Life insurance with Accidental Death and Dismemberment (AD&D).

**Add DEPENDENTS.** 7

<p><b>EMPLOYEE</b></p> <p>Policy Amount: <input checked="" type="checkbox"/> \$ <u>15,000.00</u></p> <p><i>You must be enrolled to cover your dependents.</i></p> <p><input type="checkbox"/> I Waive This Coverage.</p>	<p><b>SPOUSE</b></p> <p>Policy Amount: <input checked="" type="checkbox"/> \$ <u>10,000.00</u></p> <p><i>The amount may not be more than 50% of the employee amount.</i></p> <p><input type="checkbox"/> I Waive This Coverage.</p>	<p><b>CHILD(REN)</b></p> <p>Policy Amount: <input checked="" type="checkbox"/> \$ <u>7500.00</u></p> <p><i>The amount may not be more than 10% of the employee amount.</i></p> <p><input type="checkbox"/> I Waive This Coverage.</p>
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Deduct employee premiums only:  After Taxes.  Before Taxes. (Check with your Employer for details.)

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.** 8

Primary Beneficiary 1: First Name, Middle Initial, Last Name:	Relationship to you:	Percent :	<u>100</u> %
<u>MARY E. DOE</u>	<u>WIFE</u>		
Primary Beneficiary 2: First Name, Middle Initial, Last Name:	Relationship to you:	Percent :	_____%

*Must add up to 100%.*

Contingent Beneficiary: First Name, Middle Initial, Last Name:      Relationship to you:

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

Add [Choose your] Voluntary Life insurance with AD&D.

EMPLOYEE

SPOUSE

CHILD (REN)

Policy Amount :  
 \$ \_\_\_\_\_.

Policy Amount :  
 \$ \_\_\_\_\_.

Policy Amount :  
 \$ \_\_\_\_\_.

*You must be enrolled to cover your dependents.*

*The amount may not be more than 50% of the employee amount for Voluntary Life.*

*The amount may not be more than 10% of the employee amount for Voluntary Life.*

I Waive This Coverage.

I Waive This Coverage.

I Waive This Coverage.

Deduct employee premiums only:  After Taxes.  Before Taxes. (Check with your employer for details.)

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

Choose your Guardian Universal Life (GUL) insurance.

EMPLOYEE

EMPLOYEE ACCIDENTAL DEATH

Policy Amount:  
 \$ \_\_\_\_\_.

Premium Amount:  
 \$ \_\_\_\_\_.

Policy Amount:  
 \$ \_\_\_\_\_.

Premium Amount:  
 \$ \_\_\_\_\_.

- Current 20 Pay
- Current Level
- Minimum

I Waive This Coverage.

*You must be enrolled to cover your dependents.*

Additional Term Life for SPOUSE

Additional Term Life for CHILD(REN)

Policy Amount:  
 \$ \_\_\_\_\_.

Policy Amount:  
 \$ \_\_\_\_\_.

*The amount may not be more than 50% of the employee amount for GUL.*

*The amount may not be more than 10% of the employee amount for GUL.*

Premium Amount:  
 \$ \_\_\_\_\_.

Premium Amount:  
 \$ \_\_\_\_\_.

I Waive This Coverage.

I Waive This Coverage.

Death Benefit: The amount of death benefit that the beneficiary will receive when you die will depend on the death benefit option selected for the GUL policy.

Option 1 (Level) The beneficiary would receive the greater of: the specified insurance amount (face amount) on the date of death; or the Minimum Death Benefit as defined under IRC section 7702. The death benefit does not increase over the life of the policy.

Option 2 (Increasing) The beneficiary would receive the greater of: the specified insurance amount (face value), plus the certificate value on the date of death (surrender value); or the Minimum Death Benefit as defined under IRC section 7702. The death benefit could increase over the life of the policy.

Death Benefit Option:  Level.  Increasing.

A separate sheet for Guardian Universal Life beneficiaries is attached if they are not the same as those named for [Basic Life] [Voluntary Life] [Basic Life and/or Voluntary Life].

Will Guardian Universal Life insurance replace any existing life insurance or annuity?  Yes.  No. If "Yes.", please provide the following:

Carrier's Name: \_\_\_\_\_ Name of Insured: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Insurance Amount: \$ \_\_\_\_\_.

Have you [or your spouse] [or your spouse/Domestic Partner] used any form of tobacco in the past 6 months (e.g., pipe, chewing tobacco); and/or have you [or your spouse] [or your spouse/Domestic Partner] smoked cigarettes in the past 12 months?

11

Employee	Type:	Amount:	Spouse/[Domestic	Type:	Amount:
<input type="checkbox"/> Yes. <input checked="" type="checkbox"/> No.	(e.g. cigarettes, pipe)	(e.g., one pack/day)	Partner]	(e.g. cigarettes, pipe)	(e.g., one pack/day)
			<input type="checkbox"/> Yes. <input checked="" type="checkbox"/> No.		

**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 has the right to reject your request.
- ◆ Federal regulations limit before tax deductions for term life to the first \$50,000 of benefits (including any employer-paid benefit). If any portion of the term life premium is for dependent coverage, the entire premium must be paid after tax.
- ◆ A personalized quote from a Guardian Representative is required before electing Guardian Universal Life coverage.
- ◆ Children will not be covered until they reach 14 days of age.
- ◆ 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.
- ◆ Benefits that carry a value beyond the end of the plan year, such as Group Universal Life, may not be payroll-deducted on a pre-tax basis.

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**ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)**

**Choose your Accidental Death and Dismemberment Coverage.**

**EMPLOYEE**

Policy Amount:

\$ 25,000.00

Add Entire Family  
(includes Employee, Spouse and Child(ren)).

*You must be enrolled to cover your dependents.*

I Waive This Coverage.

I Waive This Coverage.

Deduct employee premiums only:  After Taxes.  Before Taxes. (Check with your Employer for details.)

13

**Complete if you are enrolling for AD&D coverage.**

In the last 3 years, have you flown as a pilot, crew member, or student pilot in any type of aircraft, including but not limited to an airplane, helicopter, glider or ultralight? Or, is such activity planned in the next 6 months?  Yes.  No.

In the last 3 years, have you engaged in avocations such as mountain or rock climbing, motor vehicle racing, scuba or skin diving, parachuting or skydiving? Or, is such activity planned in the next 6 months?  Yes.  No.

In the last 3 years, have you had your driver's license suspended or revoked; had 3 or more moving violations; or been charged with driving under the influence of alcohol or drugs?  Yes.  No.

If Yes, provide: Driver's License State \_\_\_\_\_, Driver's License Number \_\_\_\_\_.

If you have answered "Yes." to any of the questions above, please provide details: \_\_\_\_\_.

You must complete an Evidence of Insurability form if you answered "Yes." to any of the above questions.

**DISABILITY  
CORE PLAN**

**Choose your Short Term Disability (STD) insurance.**

**Add VOLUNTARY STD BUY-UP.**

Weekly Benefit:

\$ 250.00

Weekly Benefit:

\$ \_\_\_\_\_.

I Waive This Coverage.

Deduct employee premiums only:  After Taxes.  Before Taxes. (Check with your Employer for details.)

**Choose your Long Term Disability (LTD) insurance.**

**Add VOLUNTARY LTD BUY-UP.**

Monthly Benefit:

\$ \_\_\_\_\_.

Monthly Benefit:

\$ \_\_\_\_\_.

The sum of the amounts of your buy-up benefit and your core plan benefit may not exceed 70% of your monthly salary.

I Waive This Coverage.

Deduct employee premiums only:  After Taxes.  Before Taxes. (Check with your Employer for details.)

14

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**Complete if you are enrolling for employee-paid LTD and/or STD coverage.**

In the past two years, have you missed 5 or more consecutive work days for a sickness, injury or chronic condition other than a cold or flu?

Yes.  No.

In the past two years, have you missed more than 10 days, in total, due to a sickness, injury or chronic condition other than a cold or flu?

Yes.  No.

If you responded "Yes." to either of the above, please provide details: \_\_\_\_\_

Are you currently pregnant?  Yes.  No.  Does Not Apply.

16

You must complete an Evidence of Insurability form if you answered "Yes." to any of the above questions.

**IMPORTANT NOTES:**

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

**[Voluntary] Critical Illness**

**Choose your Critical Illness coverage**

**Add dependents.**

17A

**EMPLOYEE**

**SPOUSE**

**CHILD(REN)**

Employer Provided \$[\_\_\_\_\_]

Employer Provided \$[\_\_\_\_\_]

Employer Provided \$[\_\_\_\_\_]

OR

Employer Provided [50%] of  
Employee amount

OR

Employer Provided [50%] of  
Employee amount

You must be enrolled to cover your dependents.

Deduct employee premiums only :  After taxes  Before taxes (Check with your employer for details)

[You must answer the following if: (a) you are electing an amount over the guarantee issue ; or (b) your dependent spouse or child is electing an amount over his/her guarantee issue:

17B

Has any proposed insured been diagnosed with or treated for any of the following conditions: [ cancer, carcinoma in situ, malignant melanoma, any chronic or progressive disease of heart, kidneys, liver, lungs, pancreas, or bone marrow? ] Or , been advised to have [organ transplant, including a bone bone marrow or stem cell transplant ] ?

Employee:  Yes  No Spouse:  Yes  No Child:  Yes  No

Has the proposed insured been diagnosed with or treated for: [ heart attack or heart disease, stroke or transient ischemic attack (TIA), or have you had or been advised to have bypass surgery, stent insertions, treatment to coronary arteries ] ?

Employee:  Yes  No Spouse:  Yes  No Child:  Yes  No

Has the proposed insured been diagnosed with or treated for [ uncontrolled blood pressure (requiring a change medication or dosage in the past 6 months) or been diagnosed with or treated for diabetes ] (except if present only during pregnancy)?

Employee:  Yes  No Spouse:  Yes  No Child:  Yes  No

<Have you used any form of tobacco in the past 6 months (e.g. pipe, chewing tobacco ) and/or have you smoked cigarettes in the past 12 months?

Employee  Yes  No Spouse:  Yes  No

Has the proposed insured been absent from work for more than [10] consecutive days due to illness or injury during the past 12 months? ]

Employee  Yes  No Spouse:  Yes  No

Please indicate the Height and Weight for each proposed insured.

	Height	Weight
Employee		
Spouse		
Child		
Child		

17C

An Evidence of Insurability Form must be completed if you are electing: (a) an insurance amount in excess of [ \$25,000]; or (b) dependent spouse coverage in excess of [\$15,000].

**IMPORTANT NOTES:**

- If your coverage is not transferred from another group carrier, benefits will not be payable if they occur within the first [30] days after your effective date.
- We do not pay benefits for claims relating to you: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane.
- You must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year ; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.
- [Spouse coverage terminates on attainment of age [70].]
- This Critical Illness plan does not pay charges relating to a pre-existing condition. A pre-existing condition includes pregnancy and any condition for which an employee consults with a physician, receives treatment, or takes prescribed drugs during a specified time period prior to coverage in this plan. Please refer to your policy for details. State limitations may apply.
- [Your coverage will not be effective until approved by a Guardian underwriter.]
- If you waive Critical Illness coverage and later decide to enroll, you may have to provide, at your own expense, proof of each person's insurability. Guardian has the right to reject your request.
- [Children will not be covered until they reach [14] days of age.]
- Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Critical Illness.
- Limitations and exclusions may apply to a second ever occurrence of a Critical Illness. Please see policy for plan specifics.
- [We do not pay benefits for a third or later occurrence of a Critical Illness.]

**DENTAL**

**Choose your Dental coverage. Check one box only.**

Find dental providers online at [www.guardianlife.com](http://www.guardianlife.com) or check the directory of providers.

	EMPLOYEE ALONE	Employee & SPOUSE	Employee & CHILD (REN)	ENTIRE FAMILY
Dental Plan Option 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Dental Plan Option 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> I Waive This Coverage.			

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Deduct premiums:  After Taxes.  Before Taxes. (Check with your Employer for details.)

If you or your family has lost dental coverage, please explain below. *Late entry penalties may apply.*

Reason for Loss of coverage:

- Termination of Employment.  Divorce.  Death of Spouse.  Termination or Expiration of coverage.

Date of coverage loss:

(MM/DD/YR)

**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**

Choose your Vision coverage. Check one box only.

Find vision providers online at [www.guardianlife.com](http://www.guardianlife.com) or check the directory of providers.

	<b>EMPLOYEE ALONE</b>	<b>Employee &amp; SPOUSE</b>	<b>Employee &amp; CHILD (REN)</b>	<b>ENTIRE FAMILY</b>
Vision Plan Option 1	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Plan Option 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> I Waive This Coverage.			

Deduct premiums:  After Taxes.  Before Taxes. (Check with your Employer for details.)

**IMPORTANT NOTES:**

- ◆ Proof of insurability does not apply to vision, but if you waive vision coverage and later decide to enroll, you may be subject to delays in enrollment.
- ◆ Important Note: Your plan includes a Two Year [or] One Year Lock-In/Lock-Out Provision - Your election to enroll in or waive Vision coverage must remain in effect until your plan's next biannual [or] annual vision enrollment period.

**FLEXPLAN**

**Enroll in Premium Only Plan (POP).**

In addition to the Guardian coverage(s) already marked "Before Taxes", please include the following non-Guardian insurance premium contribution(s) in FlexPlan POP for pre-tax deduction.

Coverage: Contributions per pay period: \$ 20

Coverage: Contributions per pay period: \$

Coverage: Contributions per pay period: \$

**Enroll in Flexible Spending Account (FSA).**

Health Care Reimbursement Account (FSA) Contribution per pay period:  \$ **25.00**  
Up to \$5000 per year.

Dependent Care Reimbursement Account (FSA) Contribution per pay period:  \$ **25.00**  
Up to \$5000 per year (\$2500, if married and filing separately).

I Waive This Coverage.

21

**IMPORTANT NOTES:**

- ◆ Your employer has chosen FlexPlan as their Flexible Benefit Plan. FlexPlan covers all benefits made available under Internal Revenue Code Sections 79, 105, 106, 125 and 129, as amended from time to time. Social Security benefits may be affected, because FlexPlan elections will be deducted before your salary is taxed. If you terminate employment, the FlexPlan Plan Document will control any continued participation under the plan.
- ◆ By enrolling in FlexPlan's Premium Only Plan (POP) option, you are authorizing your employer to redirect your compensation in the amount needed to provide for your benefit selection under any group insurance, such as term life, medical, dental, vision, disability, or other qualified programs offered by your employer. Such benefits will be paid with pre-tax dollars. You will be enrolled for the full plan year and cannot change your benefit elections during the plan year, unless you experience a qualifying event (such as a change in marital status, or in the number of tax dependents). You can change your benefit elections at the beginning of each plan year. If you do not make a change at that time, your POP elections will remain the same.
- ◆ By enrolling in either of FlexPlan's Flexible Spending Account (FSA) options, you are authorizing your employer to redirect your compensation, in the amount(s) you indicate, to provide for your benefit selection under the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account. Such benefits will be paid with pre-tax dollars. You will be enrolled for the full plan year and cannot change your benefit elections during the plan year, unless you experience a qualifying event (such as a change in marital status, or in the number of tax dependents). You can change your benefit elections at the beginning of each plan year. If you do not make a change at that time, your FSA elections will cease as of the last day of the current plan year. At the end of the plan year, any unused FSA dollars will be forfeited by you.
- ◆ Your employer has chosen FlexPlan's Automatic Claims Reimbursement option, which eliminates the need for you to submit the FlexPlan Reimbursement Request Form for most eligible dental expenses that are not covered by your Guardian dental plan. If an expense cannot be automatically submitted to your Health Care FSA for reimbursement, then a statement will appear on your Explanation of Benefits (EOB), prompting you to submit the FlexPlan Reimbursement Form. If you have Coordination of Benefits (COB) through a spouse's employer, you are not eligible for this service and must decline.
- ◆ Federal regulations limit pre-tax deductions for group term life insurance to the first \$50,000 of benefit (including any employer paid benefit). If any portion of the group term life insurance premium is for dependent coverage, the entire premium must be taken post tax.
- ◆ Paying for disability income insurance pre-tax may cause the benefits to be taxable to the recipient at the time of payment.

**[MEDICAL HISTORY**

**Complete the following question if you are enrolling for one or more of the following benefits: Short Term and/or Long Term Disability; Basic Life; Voluntary Life and/or Guardian Universal Life:**

In the last 6 months have you [or any of your dependents] received medical care, including treatment, consultation, services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer; Heart Disease; Diabetes; any condition related to AIDS or AIDS Related Complex; [Uncontrolled Hypertension (requiring a change in medication or dosage in the past 6 months); Kidney Disorder; Stroke or other Cerebral Vascular Disorder; Blood Disease or Disorder; Liver Disease; Chronic Lung Disease; Neurological Disease or Disorder] [,] [Musculo-skeletal disorders, arthritis, Alzheimer's or other forms of dementia,] or any other Chronic Condition [Life threatening or disabling disease or disorder]?

Yes [, I have.]  Yes, my spouse [/Domestic Partner] has.  Yes, my child has.  No.

22

An Evidence of Insurability form must be completed for [any person with] a "Yes" answer to the question above.

**SIGNATURE**

- I hereby apply for the group coverage(s) that I have chosen above.
- I understand that I must meet the 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 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 coverages I have chosen above.
- I attest that the information provided above is true and correct to the best of my knowledge.
- 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.
- 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.
- NAIC Quotation: By signing this enrollment form, I certify that I received no illustration in the sale of Group Universal Life insurance. I understand that an illustration conforming to the coverage as issued will be provided no later than at the time of certificate delivery.

23

**SIGNATURE OF EMPLOYEE**

*John Q. Doe*

24

DATE 1/02/09

**LICENSED REPRESENTATIVE**

I certify that no illustration was used in the sale of Group Universal Life insurance. To the best of my knowledge, this insurance  Will  Will Not replace existing life insurance.

**SIGNATURE OF LICENSED REPRESENTATIVE**

**CODE**

**STATE WHERE APPLICANT SIGNED**

25

Enrollment Kit ##-####-###

26

Questions? Call the Employee Benefits Hotline (800) 000-0000

SERFF Tracking Number: GARD-126265842 State: Arkansas  
Filing Company: The Guardian Insurance & Annuity Company State Tracking Number: 43234  
Inc.  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 8292 GIAC  
Project Name/Number: /

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> Cert. of read. - 40 GIAC.pdf		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> N/A <b>Comments:</b>		

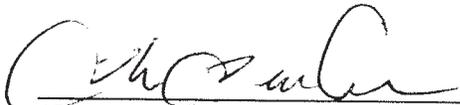
	Item Status:	Status Date:
<b>Satisfied - Item:</b> Var. memo. <b>Comments:</b> <b>Attachment:</b> cef2009varmemar.pdf		

## CERTIFICATION OF READABILITY

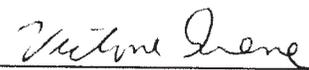
Form number(s): CEF2009

The undersigned individuals have carefully reviewed, and know the contents of, the filing submitted herewith, and except as qualified, do hereby certify the following:

1. The said form(s) meet the minimum reading ease requirements of your jurisdiction.
2. The captioned form(s) have a Flesch reading ease test score of at least 40 with no exemptions.
3. The said form(s) are printed in 10-point or larger type.

  
\_\_\_\_\_  
(Signature of Officer)

Date: 7/15/09

  
\_\_\_\_\_  
Group Contracts

## Variable Filing Memorandum Enrollment/Change Form - CEF2009

Variable material in CEF2009 is outlined and may be changed, as explained below.

This form is a generic enrollment/change form used to enroll eligible members of eligible groups. It is used when evidence of insurability may be required and contains medical questions, which, if answered affirmatively, trigger a request for detailed medical information.

In actual use, this form may be tailored for use for a specific client or for specific coverages. It may be customized for employees only, or for employees and dependents, or for dependents only. Dependent references may also be changed to specify dependent spouse only or dependent child only. References to dependent spouse may be changed to dependent spouse /domestic partner based upon applicable state law, underwriting rules and/or specific Employer request.

We reserve the right to make changes in format, design and presentation. Form elements may appear with adjoining benefit descriptions and/or enrollment instructions. Form elements may also appear online in a web-based format, in a printable PDF, or in a fillable PDF. Any corresponding disclaimers and/or footnotes to enrollment data fields will be contained within the same enrollment document at time of distribution to the eligible employees.

Specific Coverages – When a form is used for specific lines of coverages:

- References to all non-applicable coverages will be deleted.
- Requested information relevant to deleted coverages may also be deleted.
  - For example, beneficiary information will be deleted when the form is to be used with disability income; medical expense, dental expense and/or vision care expense insurance only.
  - For example, Payroll Frequency, Effective Date of Payroll Change and Effective Date of Benefit Options will be deleted when the Flexible Spending Account line of coverage is not offered.
  - Initial employee premium amounts may be shown if planholder provides adequate census information. Employee premium is subject to change according to underwriting requirements. A disclaimer has been included to notify employee that premium is initial premium only and is subject to change.

All elements of this form may be translated into Spanish.

The form has been completed with hypothetical data in the John Doe fashion. It will be replaced by actual data on a case-by-case basis.

For all provisions, we show our standard wording. We reserve the right to change this wording to reflect changes mandated by state or federal law or regulation.

Variable Number	Comments
1	Form Name – Form Name may change based on market assessment or Sales Office preference or may not appear.
2	Company Name & Brand Logo – The Company Name may be changed to reflect the coverages being enrolled. For example: <ul style="list-style-type: none"> <li>• The Guardian Life Insurance Company of America will be deleted when only enrolling coverages sold through The Guardian Insurance &amp; Annuity Company, Inc.</li> <li>• The Guardian Insurance &amp; Annuity Company, Inc. will be deleted when only enrolling coverages sold through The Guardian Life Insurance Company of America.</li> <li>• A subsidiary company name will be added if coverage is provided by a subsidiary company.</li> <li>• The Guardian Brand Logo and/or the Brand Logo of a subsidiary company will be present when they are responsible for the coverages being sold to the eligible member.</li> <li>• Company names and logos may be changed to reflect a company's name change or change in logo.</li> <li>• Company addresses may be shown, as applicable, and are subject to change.</li> </ul>

## Variable Filing Memorandum Enrollment/Change Form - CEF2009

3	<p>Employer Information –</p> <ul style="list-style-type: none"> <li>• The terminology used to refer to “Employer” may change based on market assessments or Sales Office preference. For example, “Planholder” may replace “Employer”.</li> <li>• The demographic information about the Employer may be deleted.</li> <li>• If it does appear on the form, either the eligible employee or Employer will complete the information or it may be pre-populated.</li> </ul>
4	<p>Employer Use Only –</p> <ul style="list-style-type: none"> <li>• The employer will complete this section with data about each eligible employee who completes an enrollment form.</li> <li>• Information required may be pre-populated if census information is provided.</li> <li>• Certain data elements will be deleted depending on the lines of coverage offered on the sold plan. For example, “Payroll Change Effective” will be deleted if the FlexPlan line of coverage is not offered.</li> </ul> <p>Regional Home Office Addresses –</p> <ul style="list-style-type: none"> <li>• The names and addresses of the regional office may change.</li> <li>• No, only one or multiple regional office addresses may be included.</li> </ul>
5,6	<p>Employee/Dependent Coverage –</p> <ul style="list-style-type: none"> <li>• All references to employees and dependents may be customized in all areas of this form.</li> <li>• Requested demographic information pertaining to employees and/or dependents may be deleted depending upon Sales Office preference. For example, Annual Salary/Earnings: \$, may be deleted.</li> <li>• When this form is used for employees only, or when a coverage section is for employees only, all references to dependents and requested information pertaining to dependents will be deleted.</li> <li>• When retirees are not being enrolled, all references to retirees will be deleted.</li> <li>• The terminology used to refer to “Employee” and/or “Dependents” may change based on market assessments or Sales Office preference. For example, “Member” or a first person pronoun may replace “Employee”.</li> <li>• “state of residence” will be included in this section if required by state law.</li> </ul>
7	<p>Basic Life with Accidental Death and Dismemberment (AD&amp;D) –</p> <ul style="list-style-type: none"> <li>• This section, or select questions within this section, may be deleted, depending on coverage being offered.</li> <li>• The section title may vary to reflect benefits elected or offered on a plan.</li> <li>• Specifications may change to reflect product design changes.</li> <li>• Plan specific benefit information will be included.</li> <li>• The phrase “The amount may not be more than ___% of the employee amount.” may be changed or deleted, depending on the plan design. The percentage may vary within the range of 10-100%, but will not exceed the amount allowed by any applicable law.</li> <li>• Waiver of coverage election boxes may be deleted.</li> <li>• Before Taxes and After Taxes election boxes and product specific comment will appear only if the plan offers this line of coverage as well as the Flexible Benefits plan.</li> <li>• Life Insurance Important Notes will always be included when Basic Life is on the form. The Notes may change to reflect products offered under a plan.</li> </ul>
8	<p>Beneficiary Information –</p> <ul style="list-style-type: none"> <li>• Will appear on form only when Basic Life, Optional Term Life, Guardian Universal Life and/or Flexible Benefits are offered as part of the plan.</li> <li>• An employee may indicate a trust, institution or association as a beneficiary.</li> </ul>

## Variable Filing Memorandum Enrollment/Change Form - CEF2009

9	<p>Voluntary Life with AD&amp;D –</p> <ul style="list-style-type: none"> <li>• This section, or select questions within this section, may be deleted, depending on coverage being offered.</li> <li>• The terminology used to refer to the type of coverage may change based on market assessments. For example, “voluntary” may be replaced by “optional”.</li> <li>• Specifications may change to reflect product design changes.</li> <li>• Plan specific benefit information will be included.</li> <li>• The phrase “The amount may not be more than ___% of the employee amount for Voluntary Life.” may be changed or deleted, depending on the plan design. The percentage may vary within the range of 10-100%, but will not exceed the amount allowed by any applicable law.</li> <li>• Waiver of coverage election boxes may be deleted.</li> <li>• Before Taxes and After Taxes election boxes and product specific comment will only appear if the plan offers this line of coverage as well as the Flexible Benefits plan.</li> <li>• Life Insurance Important Notes will always be included when Voluntary Life is on the form. The Notes may change to reflect products offered under a plan.</li> </ul>
10	<p>Guardian’s Universal Life –</p> <ul style="list-style-type: none"> <li>• This section, or select questions within this section, may be deleted, depending on coverage being offered.</li> <li>• Specifications may change to reflect product design changes.</li> <li>• Plan specific benefit information will be included.</li> <li>• The phrase “The amount may not be more than ___% of the employee amount for GUL.” may be changed or deleted, depending on the plan design. The percentage may vary within the range of 10-100%, but will not exceed the amount allowed by any applicable law.</li> <li>• The question regarding replacement coverage will always appear.</li> <li>• Waiver of coverage election boxes may be deleted.</li> <li>• Premium references may be deleted.</li> <li>• Life Insurance Important Notes will always be included when Guardian Universal Life is on the form. The Notes may change to reflect products offered under a plan.</li> </ul>
11	<p>Tobacco Use -</p> <ul style="list-style-type: none"> <li>• Any or all questions may be deleted based on underwriting rules and/or specific Employer request.</li> <li>• Text may be modified, based on who is enrolling; i.e. employee only, employee &amp; spouse.</li> <li>• The time frame for the use of any form of tobacco may vary within the range of 3-12 months; and the time frame for smoking cigarettes may vary within the range of 6-24 months; but will never exceed that allowed by any applicable law.</li> </ul>
12	<p>Important Notes –</p> <ul style="list-style-type: none"> <li>• The Notes may change to reflect products offered under a plan.</li> <li>• The phrase “Children will not be covered until they reach 14 days of age.” may be changed or deleted, depending on the plan design. The age may vary within the range of 14-30 days, but will not exceed the age specified by any applicable law.</li> </ul>

## Variable Filing Memorandum Enrollment/Change Form - CEF2009

13	<p>Accidental Death and Dismemberment (AD&amp;D) –</p> <ul style="list-style-type: none"> <li>• This section, or select questions within this section, may be deleted, depending on coverage being offered.</li> <li>• The question relating to flying, avocations and driving history and specific health conditions: <ul style="list-style-type: none"> <li>○ Any or all questions may be deleted based on underwriting rules and/or specific Planholder request.</li> <li>○ The time frames may vary within the range of 1-5 years and 3-12 months, respectively; but will never exceed those allowed by any applicable law. The number of moving violations may vary within the range of 1-3 violations.</li> </ul> </li> <li>• The terminology used to refer to the type of coverage may change based on market assessments. For example, “optional” may be replaced by “voluntary”.</li> <li>• The section title may vary to reflect benefits elected or offered on plan.</li> <li>• Specifications may change to reflect product design changes.</li> <li>• Plan specific benefit information will be included.</li> <li>• Waiver of coverage election boxes may be deleted.</li> </ul>
14	<p>Short Term Disability –</p> <ul style="list-style-type: none"> <li>• This section, or select questions within this section, may be deleted, depending on coverage being offered.</li> <li>• The reference to Buy Up will be deleted if the Buy Up option is not part of the plan.</li> <li>• The reference to Flex AbilityGuard will be deleted if Flex AbilityGuard is not part of the plan.</li> <li>• Specifications may change to reflect changes in product design.</li> <li>• Plan specific benefit information will be included.</li> <li>• The percentage of monthly salary may vary within the range of 60-80%, but will not exceed the amount allowed by any applicable law.</li> <li>• Waiver of coverage election boxes may be deleted.</li> <li>• Before Taxes and After Taxes election boxes and product specific comment will appear only if the plan offers this line of coverage as well as the Flexible Benefits plan.</li> <li>• Disability Important Notes will always be included when Short Term Disability is on the form. The Notes may change to reflect products offered under a plan.</li> </ul>
15	<p>Long Term Disability –</p> <ul style="list-style-type: none"> <li>• This section, or select questions within this section, may be deleted, depending on coverage being offered.</li> <li>• The reference to Buy Up will be deleted if the Buy Up option is not part of the plan.</li> <li>• The reference to Flex AbilityGuard will be deleted if Flex AbilityGuard is not part of the plan.</li> <li>• Specifications may change to reflect changes in product design.</li> <li>• Plan specific benefit information will be included.</li> <li>• The percentage of monthly salary may vary within the range of 60-80%, but will not exceed the amount allowed by any applicable law.</li> <li>• Waiver of coverage election boxes may be deleted.</li> <li>• Before Taxes and After Taxes election boxes and product specific comment will appear only if the plan offers this line of coverage as well as the Flexible Benefits plan.</li> <li>• Disability Important Notes will always be included when Long Term Disability is on the form. The Notes may change to reflect products offered under a plan.</li> </ul>

## Variable Filing Memorandum Enrollment/Change Form - CEF2009

16	<p>Questions for short term and/or long term disability –</p> <ul style="list-style-type: none"> <li>• This section will be deleted when both short term and long term disability insurance are not offered on a plan.</li> <li>• The reference to either short term or long term disability insurance will be deleted if that coverage is not an elected benefit or is not offered on a plan.</li> <li>• Any or all questions may be deleted based on underwriting rules and/or specific Planholder request.</li> <li>• The reference to “employee-paid” may be deleted based on underwriting rules.</li> <li>• The time frames for the second question may vary within the range of 1-3 years and 3-10 days, respectively. The time frames for the third question may vary within the range of 1-3 years and 5-20 days, respectively. In no event will the timeframes exceed those allowed by any applicable law.</li> <li>• The question related to pregnancy will appear only if short-term disability is offered.</li> </ul>
17A	<p>Critical Illness</p> <ul style="list-style-type: none"> <li>• The section title may vary to reflect benefits elected or offered on a plan.</li> <li>• Specifications may change to reflect product design changes.</li> <li>• Plan specific benefit information will be included.</li> <li>• Depending on the amount of premium an employee is contributing toward his/her Critical Illness coverage, questions within the Employee, Spouse &amp; Child(ren) sections may be removed.</li> <li>• Percentages and dollar amounts within the bracketed areas are variable.</li> <li>• The phrase “The amount may not be more than ___% of the employee amount.” may be changed or deleted, depending on the plan design. The percentage may vary within the range of 10-100%, but will not exceed the amount allowed by any applicable law.</li> <li>• Waiver of coverage election boxes may be deleted.</li> <li>• Before Taxes and After Taxes election boxes and product specific comment will appear only if the plan offers this line of coverage as well as the Flexible Benefits plan.</li> </ul>
17B	<p>Questions</p> <ul style="list-style-type: none"> <li>• This text may vary based on plan specifications so that reference to: (a) any single question or combination of questions may be removed; and/or (b) any particular diagnosis(es) or condition(s) may be deleted.</li> <li>• Height and weight chart may be deleted.</li> <li>• Text may be modified, based on who is enrolling; i.e. employee only; employee &amp; spouse.</li> <li>• The time frame for the use of any form of tobacco may vary within the range of 3-12 months; and the time frame for smoking cigarettes may vary within the range of 6-24 months; but will never exceed that allowed by any applicable law.</li> <li>• The time frames for the absent from work questions should be variable within the range of 3-30 days and 6-24 months.</li> </ul>
17C	<p>Important Notes</p> <ul style="list-style-type: none"> <li>• Critical Illness Important Notes may change to reflect products offered under a plan.</li> <li>• The bracketed number of days in the phrase “if your coverage is not transferred from another group carrier, benefits will not be payable if they occur within the first [30] days after your effective date.” may vary within the range of 0-90 days.</li> <li>• The phrase “Children will not be covered until they reach 14 days of age.” may be changed or deleted, depending on the plan design. The age may vary within the range of 0-30 days, but will not exceed the age specified by any applicable law.</li> <li>• Any notes regarding dependents may be removed if dependent coverage is not included.</li> <li>• Any Important Note should be able to be included or removed.</li> </ul>

## Variable Filing Memorandum Enrollment/Change Form - CEF2009

18	<p>Dental –</p> <ul style="list-style-type: none"> <li>• This section, or select questions within this section, may be deleted, depending on coverage being offered.</li> <li>• The issuing company (ies) name(s) will be changed/added to reflect a subsidiary company name if such a company provides dental coverage.</li> <li>• Specifications may change to reflect product design changes or products offered under a plan.</li> <li>• Plan specific benefit information will be included.</li> <li>• Waiver of coverage election boxes may be deleted.</li> <li>• Before Taxes and After Taxes election boxes and product specific comment will appear only if the plan offers this line of coverage as well as the Flexible Benefits plan.</li> <li>• Dental Important Notes will always be included when dental is on the form. The Notes may change to reflect products offered under a plan.</li> <li>• Referenced Website is subject to change.</li> </ul>
19	<p>Vision –</p> <ul style="list-style-type: none"> <li>• This section, or select questions within this section, may be deleted, depending on coverage being offered.</li> <li>• Specifications may change to reflect product design changes or products offered under a plan.</li> <li>• Plan specific benefit information will be included.</li> <li>• Waiver of coverage election boxes may be deleted.</li> <li>• Before Taxes and After Taxes election boxes and product specific comment will appear only if the plan offers this line of coverage as well as the Flexible Benefits plan.</li> <li>• Vision Important Notes will always be included when Vision is on the form. The Notes may change to reflect products offered under a plan.</li> <li>• Referenced Website is subject to change.</li> </ul>
20, 21	<p>Flexible Benefit Plan –</p> <ul style="list-style-type: none"> <li>• This section, or select questions within this section, may be deleted, depending on coverage being offered.</li> <li>• Either the Premium Only plan will be shown or the Premium &amp; Flexible Spending Account Plan.</li> <li>• The section title may vary to reflect benefits elected or offered on a plan.</li> <li>• Specifications may change to reflect product design changes.</li> <li>• Waiver of coverage election boxes may be deleted.</li> <li>• Plan specific benefit information will be included.</li> <li>• FlexPlan Important Notes will always be included when FlexPlan is on the form. The Notes may change to reflect products offered under a plan.</li> </ul>
22	<p>Medical History –</p> <ul style="list-style-type: none"> <li>• This section will not appear when Short Term and/or Long Term Disability, Basic Life, Voluntary Life and/or Guardian Universal Life coverage or a combination of the coverages are not being offered.</li> <li>• Any or all questions may be deleted based on underwriting rules and/or specific Employer request.</li> <li>• Text may be modified based on who is enrolling; i.e. employee only, employee and spouse.</li> <li>• Text, specifically regarding AIDS and/or HIV, may be modified to comply with any applicable law.</li> <li>• "Or any chronic condition" may be used instead of the list of specifically bracketed conditions, which begins with Uncontrolled Hypertension.</li> <li>• The time frame may vary within the range of 3-24 months but will not exceed the time frame allowed by any applicable law.</li> </ul>

## Variable Filing Memorandum Enrollment/Change Form - CEF2009

23	<p>Enrollment Notices–</p> <ul style="list-style-type: none"> <li>• Regarding the third bulleted item: <ul style="list-style-type: none"> <li>○ The reference to life or disability income coverage may be deleted if such coverage is not part of the plan.</li> <li>○ The text concerning the waiting period will be deleted if not applicable to the plan or if life and disability income coverage are not included on the plan.</li> </ul> </li> <li>• Regarding the fifth bulleted item: <ul style="list-style-type: none"> <li>○ The text may be deleted based on plan design or if plan does not include dependent life coverage.</li> <li>○ The words “is home confined” may be deleted to meet state requirements or with underwriting approval.</li> </ul> </li> <li>• Regarding the eighth bulleted item: <ul style="list-style-type: none"> <li>○ The text may vary to meet state requirements.</li> </ul> </li> <li>• Regarding the ninth bulleted item: <ul style="list-style-type: none"> <li>○ This item will be deleted if premium amounts are not shown on the form.</li> </ul> </li> <li>• Regarding the tenth bulleted item: <ul style="list-style-type: none"> <li>○ This item will be deleted if Group Universal Life (GUL) is not an elected benefit or is not offered on the plan.</li> </ul> </li> </ul>
24	<p>Signature of the Employee –</p> <ul style="list-style-type: none"> <li>• The signature may be replaced with an employee PIN (personal identification number) or digitized signature, depending on type of enrollment.</li> </ul>
25	<p>Licensed Representative Statement and Signature –</p> <ul style="list-style-type: none"> <li>• The section will be deleted if Group Universal Life (GUL) and/or Flexible Benefit Plan are not an elected benefit or are not offered by the plan.</li> </ul>
26	<p>Enrollment Kit Number and Benefits Hotline –</p> <ul style="list-style-type: none"> <li>• The Enrollment Kit Number may change or may not appear.</li> <li>• The benefits hotline name and telephone number may change or may not appear.</li> </ul>