

SERFF Tracking Number: GARD-126938434 State: Arkansas  
Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 47517  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: #9219  
Project Name/Number: /#9219

## Filing at a Glance

Company: The Guardian Life Insurance Company of America

Product Name: #9219 SERFF Tr Num: GARD-126938434 State: Arkansas  
TOI: H21 Health - Other SERFF Status: Closed-Approved- State Tr Num: 47517  
Closed  
Sub-TOI: H21.000 Health - Other Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor  
Authors: Victoria Arama, Marilyn Disposition Date: 12/16/2010  
Young, Heather Bleamer  
Date Submitted: 12/13/2010 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: #9219 Date Approved in Domicile:  
Requested Filing Mode: 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: 12/16/2010 Explanation for Other Group Market Type:  
State Status Changed: 12/16/2010  
Deemer Date: Created By: Marilyn Young  
Submitted By: Victoria Arama Corresponding Filing Tracking Number:  
PPACA: Not PPACA-Related  
Filing Description:  
Form MULTICEF 2010 is being submitted for filing and/or approval by your Department.

This form will be used with our GP-1, et al policy series currently on file with your Department and is a group enrollment form that can be used for various group coverages offered by Guardian or a Guardian subsidiary. These coverages include, Voluntary Term Life Insurance, Voluntary AD&D Insurance, Long Term Disability Insurance, Short Term Disability Insurance and Critical Illness Insurance.

SERFF Tracking Number: GARD-126938434 State: Arkansas  
 Filing Company: The Guardian Life Insurance Company of State Tracking Number: 47517  
 America  
 Company Tracking Number:  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: #9219  
 Project Name/Number: /#9219

The form is designed for maximum flexibility and ease of completion. It may be tailored on a case-by-case basis to reflect the benefits included in a particular employer's plan of group benefits. 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.

This form may also be used in an electronic format, which will be substantially similar to the paper version. Any electronic forms will capture the same data and include the same statements; however, the format may be revised to accommodate electronic nuances. 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.

## Company and Contact

### Filing Contact Information

Marilyn Young, Contract Analyst Marilyn\_Young@glic.com  
 7 Hanover Square 212-598-8762 [Phone]  
 19 H 212-919-3339 [FAX]  
 New York, NY 10004

### Filing Company Information

The Guardian Life Insurance Company of CoCode: 64246 State of Domicile: New York  
 America  
 7 Hanover Square Group Code: 429 Company Type: Life  
 New York, NY 10004 Group Name: State ID Number:  
 (212) 598-8704 ext. [Phone] FEIN Number: 13-5123390

-----

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: flat fee per application/enrollment form  
 Per Company: No

SERFF Tracking Number: GARD-126938434 State: Arkansas  
Filing Company: The Guardian Life Insurance Company of State Tracking Number: 47517  
America  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: #9219  
Project Name/Number: /#9219

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Guardian Life Insurance Company of America	\$50.00	12/13/2010	42856227

SERFF Tracking Number: GARD-126938434

State: Arkansas

Filing Company: The Guardian Life Insurance Company of  
America

State Tracking Number: 47517

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: #9219

Project Name/Number: /#9219

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	12/16/2010	12/16/2010

SERFF Tracking Number: GARD-126938434

State: Arkansas

Filing Company: The Guardian Life Insurance Company of  
America

State Tracking Number: 47517

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: #9219

Project Name/Number: /#9219

## Disposition

Disposition Date: 12/16/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: GARD-126938434 State: Arkansas

Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 47517

Company Tracking Number:

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: #9219

Project Name/Number: /#9219

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	No
<b>Supporting Document</b>	Application	Approved-Closed	No
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	No
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved-Closed	No
<b>Supporting Document</b>	Variable Memorandum	Approved-Closed	No
<b>Form</b>	Enrollment/Change Form	Approved-Closed	No

SERFF Tracking Number: GARD-126938434 State: Arkansas  
 Filing Company: The Guardian Life Insurance Company of State Tracking Number: 47517  
 America  
 Company Tracking Number:  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: #9219  
 Project Name/Number: /#9219

## Form Schedule

Lead Form Number: MULTICEF 2010

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/16/2010	MULTICEF 2010	Application/Enrollment/Change Enrollment Form	Form	Initial		0.000	MULTICEF 2010.pdf

ENROLLMENT/CHANGE FORM <span style="border: 1px solid black; padding: 2px;">1</span>			
Guardian Logo			
<span style="border: 1px solid black; padding: 2px;">2</span>			
The Guardian Life Insurance Company of America			
Planholder Name (Company Name)			Guardian Group Plan Number: <span style="border: 1px solid black; padding: 2px;">3</span>
Planholder Street Address	City	State	Zip

<b>EMPLOYER USE ONLY:</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Annual Re-enrollment <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name <input type="checkbox"/> Drop Coverage as of: (MM/DD/YR)			
Class:	Hours Worked:	Division:	Benefit Effective: <span style="border: 1px solid black; padding: 2px;">4</span>
Keep a copy for your records and return form to:			
<input type="checkbox"/> Midwest Regional Office P.O. Box 8012 Appleton, WI 54912-8012	<input type="checkbox"/> Northeast Regional Office P.O. Box 26050 Lehigh Valley, PA 18002-6050	<input type="checkbox"/> Western Regional Office P.O. Box 2454 Spokane, WA 99210-2454	

<b>ABOUT YOURSELF</b> - Please print clearly and in black or blue ink.			
First Name, Middle Initial, Last Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (MM/DD/YR)	Social Security Number: <span style="border: 1px solid black; padding: 2px;">5</span>
Address 1:	City:	State:	Zip:
The best way to reach you: <input type="checkbox"/> Day Phone <input type="checkbox"/> Evening Phone <input type="checkbox"/> Email	Day Phone #	Evening Phone#	Preferred Email
Job Title:	Work Status/Eligibility: <input type="checkbox"/> Full-Time. <input type="checkbox"/> Part-Time. <input type="checkbox"/> Retired. <input type="checkbox"/> COBRA/State Continuation. Since (MM/DD/YR):	Annual Salary/Earnings: \$ _____	

<b>MULTI-COVERAGE PLAN</b>	
<input type="checkbox"/> I elect Employee coverage.	<input type="checkbox"/> I waive this coverage.
\$ _____ Voluntary Term Life Insurance \$ _____ Voluntary AD&D Insurance \$ _____ per Month Long Term Disability Income Insurance (max of 66 2/3% of salary) \$ _____ per Week Short Term Disability Income Insurance (max of 66 2/3% of salary) \$ _____ Critical Illness Insurance	<span style="border: 1px solid black; padding: 2px;">6</span>

NAME YOUR BENEFICIARIES – MUST ADD UP TO 100%	
PRIMARY BENEFICIARY 1	PRIMARY BENEFICIARY 2
Name (Last, First, MI)	Name (Last, First, MI) <span style="float: right; border: 1px solid black; padding: 2px;">7</span>
Relationship to you: %	Relationship to you: %
<b>If the designated primary beneficiaries are deceased, the contingent beneficiary/beneficiaries will receive the benefit.</b>	
CONTINGENT BENEFICIARY 1	CONTINGENT BENEFICIARY 2
Name (Last, First, MI)	Name (Last, First, MI)
Relationship to you: %	Relationship to you: %
<b>IMPORTANT NOTES:</b>	
<ul style="list-style-type: none"> <li>• 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.</li> <li>• Federal regulations limit before tax deductions for term life to the first \$50,000 of benefits (including any employer-paid benefit).</li> <li>• Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Voluntary Term Life Insurance.</li> <li>• Paying for disability income insurance pre-tax may cause the benefits to be taxable to the recipient at the time of payment. <span style="float: right; border: 1px solid black; padding: 2px;">8</span></li> </ul>	

**Complete the following question if you are enrolling for Voluntary Life and you are applying for Life amounts over \$10,000 for employees age 65-69 and for all amounts for employees age 70+:**

In the last 6 months have you 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; Kidney Disorder; Stroke or other Cerebral Vascular Disorder; Liver Disease; Chronic Lung Disease; Neurological Disease or Disorder; or any other Chronic Condition or disabling disease or disorder?

Yes, I have.  No, I have not. 9

A Critical Illness Evidence of Insurability form must be completed for employees age 70+. Evidence of Insurability is required for late entrants.

**CRITICAL ILLNESS 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.
- This Critical Illness plan does not pay charges relating to a pre-existing condition. A pre-existing condition includes 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.
- Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Critical Illness. 10
- 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.

**PLEASE READ THE REVERSE SIDE OF THIS FORM  
PLEASE READ AND SIGN THE SIGNATURE SECTION ON THE REVERSE SIDE OF THIS FORM**

**SIGNATURE**

- I hereby apply for the group benefit(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 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.

11

Any person who knowingly and 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 thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

**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.

SIGNATURE OF EMPLOYEE

12

DATE

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

13

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

## Fraud Warning Statements

**The laws of several states require the following statements to appear on the enrollment form:**

**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: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**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.

**Maine, 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 and 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.

**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.

SERFF Tracking Number: GARD-126938434

State: Arkansas

Filing Company: The Guardian Life Insurance Company of  
America

State Tracking Number: 47517

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: #9219

Project Name/Number: /#9219

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> Cert. of read. - 40.pdf	Approved-Closed	12/16/2010

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> N/A <b>Comments:</b>	Approved-Closed	12/16/2010

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Health - Actuarial Justification <b>Bypass Reason:</b> N/A <b>Comments:</b>	Approved-Closed	12/16/2010

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Outline of Coverage <b>Bypass Reason:</b> N/A <b>Comments:</b>	Approved-Closed	12/16/2010

	Item Status:	Status Date:
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary <b>Bypass Reason:</b> N/A <b>Comments:</b>	Approved-Closed	12/16/2010

SERFF Tracking Number: GARD-126938434

State: Arkansas

Filing Company: The Guardian Life Insurance Company of  
America

State Tracking Number: 47517

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: #9219

Project Name/Number: /#9219

**Item Status:**

**Status**

**Satisfied - Item:** Variable Memorandum

Approved-Closed

**Date:**

12/16/2010

**Comments:**

**Attachment:**

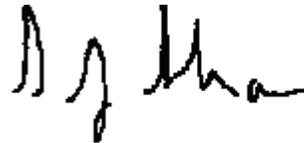
MULTICEF 2010 - Variable Memorandum.pdf

## CERTIFICATION OF READABILITY

Form number(s): MULTICEF 2010

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: 12/10/10

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

## Variable Filing Memorandum Enrollment/Change Form – MULTICEF 2010

Variable material in MULTICEF 2010 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.

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.

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 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>
3	Employer Information – <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	Employer Use Only – <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> </ul> Regional Home Office Addresses – <ul style="list-style-type: none"> <li>• The names and addresses of the regional office may change.</li> </ul>
5	About Yourself – <ul style="list-style-type: none"> <li>• All references to employees may be customized in all areas of this form.</li> <li>• Requested demographic information pertaining to employees may be deleted depending upon Sales Office preference. For example, Annual Salary/Earnings: \$, may 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” may change based on market assessments or Sales Office preference. For example, “Member” or a first person pronoun may replace “state of residence” will be included in this section if required by state law.</li> </ul>

## Variable Filing Memorandum Enrollment/Change Form – MULTICEF 2010

6	<p>Offered Plans –</p> <ul style="list-style-type: none"> <li>• The terminology used to refer to “MULTI-COVERAGE PLAN” may change based on coverage offered.</li> <li>• All options or any combination of options may be offered. Coverages may be removed depending on plan design.</li> <li>• Coverage amounts whether shown in dollars or percentages will vary based on coverage selected.</li> </ul>
7	<p>Beneficiary Information –</p> <ul style="list-style-type: none"> <li>• Will appear on form only when Voluntary Term Life Insurance is offered as part of the plan.</li> <li>• An employee may indicate a trust, institution or association as a beneficiary.</li> </ul>
8	<p>Important Notes –</p> <ul style="list-style-type: none"> <li>• The Notes may change to reflect products offered under a plan.</li> </ul>
9	<p>Medical History –</p> <ul style="list-style-type: none"> <li>• Text may be modified based on planholder selection for coverage amount and employee age.</li> <li>• Question may be deleted based on underwriting rules, products offered and/or specific Employer request.</li> <li>• Text may be modified to delete one or more conditions.</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> <li>• The text “A Critical Illness Evidence of Insurability form must be completed for employees age 70+.” will be deleted if Critical Illness is not offered.</li> </ul>
10	<p>Critical Illness 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>• Any Important Note should be able to be included or removed.</li> </ul>
11	<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>• The fraud warnings may be revised to comply with state requirements.</li> </ul>
12	<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>
13	<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>