

SERFF Tracking Number: GARD-128518955 State: Arkansas
Filing Company: The Guardian Life Insurance Company of America State Tracking Number:
Company Tracking Number: 9664AR
TOI: ML02 Multi-Line - Other Sub-TOI: ML02.000 Multi-Line - Other
Product Name: CEF2012 Enrollment Form (Life & Health)
Project Name/Number: 2012 Enrollment form /9664AR

Filing at a Glance

Company: The Guardian Life Insurance Company of America

Product Name: CEF2012 Enrollment Form (Life SERFF Tr Num: GARD-128518955 State: Arkansas & Health)

TOI: ML02 Multi-Line - Other

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

Sub-TOI: ML02.000 Multi-Line - Other

Co Tr Num: 9664AR

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird, Rosalind
Minor, Donna Lambert

Authors: Victoria Arama, Marilyn
Young, Melanie Glassic, Michael
Hambleton, Gina Giaquinto, Karen
Higgins

Disposition Date: 07/02/2012

Date Submitted: 06/29/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2012 Enrollment form

Status of Filing in Domicile: Not Filed

Project Number: 9664AR

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

Group Market Type: Employer, Association, Discretionary, Trust, Other

Explanation for Other Group Market Type: "We
would like to utilize this Group Enrollment Form
for use with eligible groups as defined by
Arkansas.

Overall Rate Impact:

Filing Status Changed: 07/02/2012

State Status Changed: 07/02/2012

Deemer Date:

Created By: Michael Hambleton

Submitted By: Victoria Arama

Corresponding Filing Tracking Number:

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Filing Description:

The captioned form is being submitted for filing and/or approval by your Department. The form will be used with our GP-1 policy series currently on file with your Department.

Form CEF2012 is a group enrollment form that can be used for all group coverages offered by Guardian or a Guardian subsidiary including Dental Insurance, Vision Insurance, Term Life Insurance, Voluntary Term Life Insurance, Accidental Death and Dismemberment Insurance, Long Term Disability Insurance, Short Term Disability Insurance and Critical Illness Insurance.

A similar form, CEF2011 was recently reviewed and approved by your Department on 3/26/12 under SERFF Tracking Number GARD-128196018. Form CEF2012 includes two additional coverage options; Accident Coverage and Cancer Coverage, as well as some other minor revisions. A redline version is being provided for ease of review.

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 of 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.

The captioned form is being submitted in "final-print" format for filing purposes. In actual use, it may be prepared on a case-by-case basis as explained above.

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

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.

Since the new form was developed for use in your jurisdiction, it will not be filed with our domiciliary state, New York, until approved by your Department.

The appropriate filing fee is being provided via Electronic Funds Transfer (EFT).

Rates are not impacted.

Your early consideration of this submission is greatly appreciated.

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State Narrative:

Company and Contact

Filing Contact Information

Gina Giaquinto, Contract Analyst Gina_Giaquinto@glic.com
 7 Hanover Square 212-919-8794 [Phone]
 New York, NY 10004 212-919-9336 [FAX]

Filing Company Information

The Guardian Life Insurance Company of America CoCode: 64246 State of Domicile: New York
 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 for enroll. form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Guardian Life Insurance Company of America	\$50.00	06/29/2012	60557645

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	07/02/2012	07/02/2012

SERFF Tracking Number: GARD-128518955 *State:* Arkansas
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America
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Disposition

Disposition Date: 07/02/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Name Change Endorsement	Approved-Closed	Yes
Supporting Document	Address Change Endorsement	Approved-Closed	Yes
Supporting Document	Variable Memorandum	Approved-Closed	Yes
Supporting Document	Redlined form and var. memo.	Approved-Closed	Yes
Supporting Document	Cert. of read.	Approved-Closed	Yes
Form	Enrollment/Change form	Approved-Closed	Yes

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 America
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Form Schedule

Lead Form Number: CEF2012

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/02/2012	CEF2012	Application/Enrollment/Change Enrollment form Form	Initial		46.300	CEF2012, v1 06-26- 2012.pdf



The Guardian Life Insurance Company of America

And its Affiliates and Subsidiaries

^{2A}[Midwest Regional Office

^{2B}[Northeast Regional Office

P.O. Box 8012, Appleton, WI 54912-8012] P.O. Box 26050, Lehigh Valley, PA 18002-6050]]

A

³[Enrollment/Change Form]

Page 1 of X

Please print clearly and mark carefully.

Employer Name: _____	³ [Group Plan Number: _____]	Benefits Effective: _____	B
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PLEASE CHECK APPROPRIATE BOX ¹ [<input type="checkbox"/> Initial Enrollment] ¹ [<input type="checkbox"/> Re-Enrollment] ¹ [<input type="checkbox"/> Add Employee/Dependents] ¹ [<input type="checkbox"/> Drop/Refuse Coverage] ¹ [<input type="checkbox"/> Information Change]			
¹ [<input type="checkbox"/> Increase Amount] ¹ [<input type="checkbox"/> Family Status Change]			

² [Class: _____]	² [Division: _____]	² [Subtotal Code: _____]	(Please obtain this from your Employer)
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About You: First, MI, Last Name: _____	C
Social Security Number ____ - ____ - ____	

Address/City/State/Zip: _____	
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Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth (mm-dd-yy): ____ - ____ - ____	¹ [Phone: () - ____ - ____]
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¹ [Email Address: _____]	Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage/union: ____ - ____ - ____
	Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placement date of adopted child: ____ - ____ - ____

¹ [² About Your Job: _____]	³ [Hours worked per week: _____]	³ [Job Title: _____]	D
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³ [Work] Status: ³ [<input type="checkbox"/> Active] ⁵ [<input type="checkbox"/> Retired] ³ [<input type="checkbox"/> Cobra/State Continuation]	³ [Date of full time hire: ____ - ____ - ____]	⁴ [Annual Salary: \$ _____ Do not include bonus/commissions]
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¹[**About Your Family:** Please include the names of the dependents you wish to enroll for coverage. *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 exception. 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.*

Spouse (First, MI, Last Name)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ² [<input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent] ³ [State of Residence: _____]
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ² [<input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent] ³ [State of Residence: _____]
Child/Dependent 3:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ² [<input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent] ³ [State of Residence: _____]
Child/Dependent 4:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ² [<input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent] ³ [State of Residence: _____]

<p>1[Drop Coverage:] <input type="checkbox"/> Drop Employee <input type="checkbox"/> Drop Dependents The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage ____-____-____</p> <p><input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement] 2[Last Day worked: ____-____-____]</p> <p><input type="checkbox"/> Other Event: _____ Date of Event: ____ - ____ - ____]</p>	<p>3[Coverage Being Dropped:]</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Dental</td> <td><input type="checkbox"/> Employee</td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Child(ren)</td> </tr> <tr> <td><input type="checkbox"/> Vision</td> <td><input type="checkbox"/> Employee</td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Child(ren)</td> </tr> <tr> <td><input type="checkbox"/> Basic Life</td> <td><input type="checkbox"/> Employee</td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Child(ren)</td> </tr> <tr> <td><input type="checkbox"/> AD&D</td> <td><input type="checkbox"/> Employee</td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Child(ren)</td> </tr> <tr> <td><input type="checkbox"/> Critical Illness</td> <td><input type="checkbox"/> Employee</td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Child(ren)</td> </tr> <tr> <td><input type="checkbox"/> Voluntary Life</td> <td><input type="checkbox"/> Employee</td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Child(ren)</td> </tr> <tr> <td><input type="checkbox"/> Accident</td> <td><input type="checkbox"/> Employee</td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Child(ren)</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Employee</td> <td><input type="checkbox"/> Spouse</td> <td><input type="checkbox"/> Child(ren)</td> </tr> <tr> <td><input type="checkbox"/> Long Term Disability</td> <td><input type="checkbox"/> Short Term Disability</td> <td></td> <td></td> </tr> </table> <p>I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____] (additional information may be required)</p>	<input type="checkbox"/> Dental	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Vision	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Basic Life	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> AD&D	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Critical Illness	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Voluntary Life	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Accident	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Cancer	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Short Term Disability			<p>4[Loss Of Other Coverage:] I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to: 2[<input type="checkbox"/> Termination of Employment: ____-____-____] <input type="checkbox"/> Divorce ____-____-____ <input type="checkbox"/> Death of Spouse ____-____-____ <input type="checkbox"/> Termination/Expiration of Coverage ____-____-____ Coverage Lost 5[<input type="checkbox"/> Dental] 5[<input type="checkbox"/> Vision]]</p>
<input type="checkbox"/> Dental	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)																																			
<input type="checkbox"/> Vision	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)																																			
<input type="checkbox"/> Basic Life	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)																																			
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<input type="checkbox"/> Critical Illness	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)																																			
<input type="checkbox"/> Voluntary Life	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)																																			
<input type="checkbox"/> Accident	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)																																			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)																																			
<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Short Term Disability																																					

F

<p>1[2[Dental Coverage:] 3[You must be enrolled to cover your dependents. Check only one box.]</p> <p>Employee Only 4[EE & Spouse] 4[EE & Dependent/Child(ren)] 4[EE, Spouse & Dependent/Child(ren)]</p> <p>5[PPO] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>5[DHMO] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>• 6[If 5[Pre Paid/DHMO] is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit 7[guardianlife.com] for a list of providers. If you do not select a PCD, one will be assigned for you.</p> <p>Employee _____ 3[Spouse _____ Child(ren) _____]]</p> <p>8[<input type="checkbox"/> I do not want this coverage. If you do not want Dental Coverage, please mark all that apply: <input type="checkbox"/> I am covered under another Dental plan. <input type="checkbox"/> My spouse is covered under another Dental plan. <input type="checkbox"/> My dependents are covered under another Dental plan.]]</p>	<p style="text-align: right;">G</p>
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G

<p>1[2[Vision Coverage:] 3[You must be enrolled to cover your dependents. Check only one box.]</p> <p>Employee Only 4[EE & Spouse] 4[EE & Dependent/Child(ren)] 4[EE, Spouse & Dependent/Child(ren)]</p> <p>5[VSP] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>5[Davis Vision] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>6[<input type="checkbox"/> I do not want this coverage. If you do not want Vision Coverage, please mark all that apply: <input type="checkbox"/> I am covered under another Vision plan. <input type="checkbox"/> My spouse is covered under another Vision plan. <input type="checkbox"/> My dependents are covered under another Vision plan.]]</p>	<p style="text-align: right;">H</p>
---	--

H

I

¹²[Dental Tied To Vision Coverage:] ³[You must be enrolled to cover your dependents. Check only one box.]

When electing Dental coverage for (yourself ³[and/or your dependents]) you also receive Vision Coverage.

Employee Only ⁴[EE & Spouse] ⁴[EE & Dependent/Child(ren)] ⁴[EE, Spouse & Dependent/Child(ren)]

⁵[PPO]
⁵[MDG]

⁶[If ⁴[Pre Paid/DHMO] is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit ⁷[guardianlife.com] for a list of providers. If you do not select a PCD, one will be assigned for you.

Employee _____ ³[Spouse _____ Child(ren) _____]]

⁸[I do not want this coverage. If you do not want this Coverage, please mark all that apply:
 I am covered under another Dental plan Yes No Vision plan Yes No
 My spouse is covered under another Dental plan Yes No Vision plan Yes No
 My dependents are covered under another Dental plan Yes No Vision plan Yes No]]

J

¹²[Dental Tied To Critical Illness Coverage:] ³[You must be enrolled to cover your dependents. Check only one box.]

When electing dental (for yourself ³[and/or your dependents]) you also receive:

⁴[\$ _____] of Critical Illness coverage for yourself. ³⁴[\$ _____] of Critical Illness coverage for your spouse.]

³⁴[\$ _____] of Critical Illness coverage for your dependent children.]

Employee Only ³[EE & Spouse] ³[EE & Dependent/Child(ren)] ³[EE, Spouse & Dependent/Child(ren)]

- ⁵[If ⁴[Pre Paid /DHMO] is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit ⁶[guardianlife.com] for a list of providers. If you do not select a PCD, one will be assigned for you.

Employee _____ ³[Spouse _____ Child(ren) _____]]

⁷[I do not want this coverage. If you do not want this Coverage, please mark all that apply:
 I am covered under another Dental plan.
 My spouse is covered under another Dental plan.
 My dependents are covered under another Dental plan.]]

K

¹²[Basic Life Coverage ²[With Accidental Death and Dismemberment (AD&D):] ³[You must be enrolled to cover your dependents. Check only one box.]

^{4A}[Benefit reductions apply. Please see plan administrator.] ^{4B}[Employees age 65+ Benefit reductions apply. Please see plan administrator.]

Policy Amount

Employee Only

⁵[200%] of your annual salary to maximum ⁶[\$9,999,999]
 ⁴[200%] of your annual salary to maximum ⁴[\$9,999,999]

⁸[I do not want this coverage.]

³[Spouse

⁶[\$5,000]
**The amount may not be more than ⁷[50%] of the employee amount]*

⁸[I do not want this coverage.]

³[Child/Dependent

⁶[\$2,500]
**The amount may not be more than ⁷[10%] of the employee amount.]*

⁸[I do not want this coverage.]

¹⁰[If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy. \$ _____]

¹²[Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Basic Life.]

⁹[Name your beneficiaries: (primary beneficiary percentages must total 100%)

Primary Beneficiaries:

Name: _____ ¹³[Social Security Number: _____ - _____ - _____] % _____

¹³[Date of Birth: Date of Birth (mm-dd-yy): ____ - ____ - ____] ¹³[Address/City/State/Zip: _____]

¹³[Phone: () -] Relationship to employee: _____

Name: _____ ¹³[Social Security Number: _____ - _____ - _____] % _____

¹³[Date of Birth: Date of Birth (mm-dd-yy): ____ - ____ - ____] ¹³[Address/City/State/Zip: _____]

¹³[Phone: () -] Relationship to employee: _____

Contingent Beneficiary Name: _____ ¹³[Social Security Number: _____ - _____ - _____]

¹³[Date of Birth: Date of Birth (mm-dd-yy): ____ - ____ - ____] ¹³[Address/City/State/Zip: _____]

¹³[Phone: () -] Relationship to employee: _____

(In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. ¹¹[Employer maintains beneficiary information.]])

¹²[Voluntary Term Life Coverage] ²[With [Accidental Death and Dismemberment (AD&D):] ³[You must be enrolled to cover your dependents. Check only one box.]

L

^{4A}[Benefit reductions apply. Please see plan administrator.] ^{4B}[Employees age 65+ Benefit reductions apply. Please see plan administrator.]

Policy Amount Check one box only.

⁵[\$25,000] ⁵[\$50,000] ⁵[\$75,000] ⁵[\$100,000*] ⁵[\$150,000**]

⁶[*Guarantee Issue Amount

**Guarantee Issue Amount plus Additional Amount]

⁸[I do not want this coverage.]

³[Add Voluntary Life for Spouse

⁷[50%] of employee's amount to maximum ⁵[\$50,000]

* The amount may not be more than ⁷[50%] of the employee amount for Voluntary Life.]

⁶[Spouse Guarantee Issue amount : ⁵[\$50,000]

⁸[I do not want this coverage.]

³[Add Voluntary Life for Dependent/Child(ren)

⁷[10%] of employee's amount to maximum

⁵[\$10,000] * The amount may not be more than ⁷[10%] of the employee amount for Voluntary Life.]

⁶[Child Guarantee Issue amount: ⁵[\$10,000]]

⁸[I do not want this coverage.]

⁹[Have you used any form of tobacco in the past ¹⁰[6] months (e.g. pipe, chewing tobacco) and/or have you smoked cigarettes in the past ¹⁰[12] months?

Employee Yes No ³[Spouse Yes No]]

¹³[Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.]

¹¹[Name your beneficiaries: (primary beneficiary percentages must total 100%) ¹²[If electing different beneficiaries that are not the same as those named for Basic Life, please name below.]

Primary Beneficiaries:

Name: _____ ¹⁵[Social Security Number: _____ - _____ - _____] % _____

¹⁵[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ¹⁵[Address/City/State/Zip: _____]

¹⁵[Phone: () -] Relationship to employee: _____

Name: _____ ¹⁵[Social Security Number: _____ - _____ - _____] % _____

¹⁵[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ¹⁵[Address/City/State/Zip: _____]

¹⁵[Phone: () -] Relationship to employee: _____

Contingent Beneficiary Name: _____ ¹⁵[Social Security Number: _____ - _____ - _____]

¹⁵[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ¹⁵[Address/City/State/Zip: _____]

¹⁵[Phone: () -] Relationship to employee: _____

(In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. ¹⁴[Employer maintains beneficiary information.])

¹²[Voluntary Accidental Death and Dismemberment (AD&D) Coverage:] ⁵[You must be enrolled to cover your dependents. Check only one box.]

M

**Employee Only
Policy Amount**

Check only one box.

³[\$25,000] ³[\$50,000] ³[\$75,000]

³[\$100,000] ³**\$150,000]

⁴[*Guarantee Issue Amount]

⁴[**Guarantee Issue Amount plus Additional Amount]

⁸[I do not want this coverage.]

⁵[Spouse

Check only one box.

⁶[50%] of employee's amount to a maximum of ⁷[\$50,000].

*The amount may not be more than ⁶[50%] of the employee amount for Voluntary Life.]

⁸[I do not want this coverage.]

⁵[Child(ren)

Check only one box.

⁶[10%] of employee's amount to a maximum of ⁷[\$10,000.]

*The amount may not be more than ⁶[10%] of the employee amount for Voluntary Life.]

⁸[I do not want this coverage.]

¹²[Short -Term Disability (STD) Coverage:]

⁶[Core] Weekly Benefit

³[60%] of salary to a maximum of ^{4A}[\$250]

⁷[I do not want this coverage.]

⁵[Buy-Up Option 1

Weekly Benefit

³[60%] of salary to a maximum of ^{4A}[\$500]

⁷[I do not want this coverage.]]

⁵[Buy-Up Option 2

Weekly Benefit

³[60%] of salary to a maximum of ^{4A}[\$700]

⁷[I do not want this coverage.]]

N

¹²[Long-Term Disability (LTD) Coverage:]

⁶[Core]

Monthly benefit

³[60%] of salary to a maximum of ^{4B}[\$5,000]

⁷[I do not want this coverage.]]

⁵[Buy Up

Monthly Benefit

³[____ %] of salary to a maximum of ^{4B}[\$_____]

⁷[I do not want this coverage.]]

⁸[Complete if you are enrolling for employee-paid ⁸[STD] and/or ⁸[LTD] Coverage.

In the past ⁹[two] years, have you missed ¹⁰[5] or more consecutive work days for a sickness, injury or chronic condition other than a cold or flu? Yes No

In the past ⁹[two] years, have you missed more than ¹¹[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. _____

¹²[Are you currently pregnant? Yes No Does not apply]

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

¹²[Multi-Coverage Plan:]

I elect ³[Employee] Coverage

⁴[\$ _____] ⁵[Voluntary Term Life Insurance]

⁴[\$ _____] ⁵[Voluntary AD&D insurance]

⁴[\$ _____] ⁵[per Month Long Term Disability Income Insurance (max of 66 2/3% of salary)]

⁴[\$ _____] ⁵[per Week Short Term Disability Income Insurance (max of 66 2/3% of salary)]

⁴[\$ _____] ⁵[Critical Illness Insurance]

⁵[Dental Coverage]

⁵[Accident]

⁵[Vision Coverage]

⁵[Cancer]

⁶[I do not want this coverage.]

⁷[Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for [Critical Illness and Voluntary Term Life].]

¹²[Critical Illness Coverage:] ³[You must be enrolled to cover your dependents.]

^{4A}[Benefit reductions apply. Please see plan administrator.] ^{4B}[Employees age 65+ Benefit reductions apply. Please see plan administrator

⁵[Core Insurance Amount : ⁶[\$500] ⁶[\$5,000] ⁶[\$10,000] ⁶[\$25,000]

⁷[I do not want this coverage.]

⁵[Buy up Insurance Amount: ⁶[\$50,000]

⁷[I do not want this coverage.]

⁵[Spouse Insurance Amount ⁶[\$25,000] The amount may not be more than ⁸[50%] of Employee Amount

⁷[I do not want this coverage.]

⁵[Dependent/Child(ren) Insurance Amount: ⁶[\$5,000] The amount may not be more than ⁸[50%] of Employee Amount.

⁷[I do not want this coverage.]

⁹[Have you used any form of tobacco in the past ¹⁰[6] months (e.g. pipe, chewing tobacco) and/or have you smoked cigarettes in the past ¹⁰[12] months? Employee Yes No ²[Spouse Yes No]]

¹¹[If you ³[or your dependent spouse or dependents] elect ²[Critical Illness Coverage], you must answer the following health questions.]

¹²[1. Has any proposed insured been diagnosed with or treated for any of the following conditions: ¹²[cancer], ¹²[carcinoma in situ], ¹²[malignant melanoma], ¹²[any chronic or progressive disease of heart], ¹²[kidneys], ¹²[liver], ¹²[lungs], ¹²[pancreas] or ¹²[bone marrow]? Or, been advised to have an ¹²[organ transplant], including ¹²[bone marrow] or ¹²[stem cell transplant]?

Employee Yes No ³[Spouse Yes No] Dependent Child(ren) Yes No]

2. Has the proposed insured been diagnosed with or treated for: ¹²[heart attack] or ¹²[heart disease], ¹²[stroke] or ¹²[transient ischemic attack (TIA)], or been advised to have ¹²[bypass surgery], ¹²[stent insertions] ¹²[treatment for coronary arteries]?

Employee Yes No ³[Spouse Yes No] Dependent Child(ren) Yes No]

3. Has the proposed insured been diagnosed with or treated for ¹²[uncontrolled blood pressure] (requiring a change in medication or dosage in the past ¹²[6 months] or been diagnosed with or treated for ¹²[diabetes] (except if present only in pregnancy) Employee Yes No ³ [Spouse Yes No] Dependent Child(ren) Yes No]]

¹⁴[Important Notes:

- Based on your plan benefits and age you may be required to complete an additional evidence of insurability form for Critical Illness.]]

¹[²Accident Coverage]: ³[You must be enrolled to cover your dependents. Check only one box.]

Q

	Employee Only	⁴ [EE & Spouse]	⁴ [EE & Dependent/Child(ren)]	⁴ [EE, Spouse & Dependent/Child(ren)]
⁵ [Value Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
⁵ [Advantage Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
⁵ [Premier Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	⁶ [<input type="checkbox"/> I do not want this coverage.]	⁶ [<input type="checkbox"/> I do not want this coverage.]	⁶ [<input type="checkbox"/> I do not want this coverage.]	⁶ [<input type="checkbox"/> I do not want this coverage.]

⁷[Name your beneficiaries: (Primary beneficiary percentages must total 100%)]

Primary Beneficiaries:

Name: _____ ⁹[Social Security Number: _____ - _____ - _____] % _____

⁹[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ⁹[Address/City/State/Zip: _____]

⁹[Phone: () -] Relationship to employee: _____

Name: _____ ⁹[Social Security Number: _____ - _____ - _____] % _____

⁹[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ⁹[Address/City/State/Zip: _____]

⁹[Phone: () -] Relationship to employee: _____

Contingent Beneficiary Name: _____ ⁹[Social Security Number: _____ - _____ - _____]

⁹[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ⁹[Address/City/State/Zip: _____]

⁹[Phone: () -] Relationship to employee: _____

(In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. ⁸[Employer maintains beneficiary information.])

¹[²Cancer Coverage]: ³[You must be enrolled to cover your dependents. Check only one box.]

R

	Employee Only	⁴ [EE & Spouse]	⁴ [EE & Dependent/Child(ren)]	⁴ [EE, Spouse & Dependent/Child(ren)]
⁵ [Value Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
⁵ [Advantage Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
⁵ [Premier Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	⁶ [<input type="checkbox"/> I do not want this coverage.]	⁶ [<input type="checkbox"/> I do not want this coverage.]	⁶ [<input type="checkbox"/> I do not want this coverage.]	⁶ [<input type="checkbox"/> I do not want this coverage.]

⁷[Complete the following question if you are enrolling for Cancer coverage. ⁸[NOTE: Additional information may be required.]]

Has anyone to be covered been treated for or diagnosed as having ⁹[Cancer in any form] ¹¹[except non melanoma skin cancer], a ⁹[pre-leukemic condition], ⁹[a pre-malignant condition or a condition with malignant potential: ¹¹[(such as colon polyps or pre-cancerous moles)] ¹¹[(except colon polyps and pre-cancerous moles)] ⁹[the following pre-malignant conditions or conditions with malignant potential: (i) colon polyps: (ii) pre-cancerous moles], ⁹[Acquired Immune Deficiency Syndrome (AIDS)] or ⁹[AIDS Related Complex (ARC)] within the last ¹⁰[10] years?

Yes, I have. No, I haven't. ³[Yes, my spouse has. No, my spouse hasn't.] ³[Yes, my dependent child(ren) have. No, my child(ren) haven't.]

¹[²Health History:]

S

Complete the following question if you are enrolling for one or more of the following benefits listed below. NOTE: Additional information may be required.

⁴[Short Term Disability] ⁴[Long Term Disability] ⁴[Basic Life Insurance] ⁴[Voluntary Life Insurance]

³[In the last ⁶[6] months have you ⁵[or any of your ³dependents] received medical care, including treatment, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: ³[Cancer], ³[Heart Disease], ³[Diabetes]; any condition related to ³[Acquired Immune Deficiency Disorder (AIDS)] or ³[AIDS Related Complex]; or any other Chronic Condition?]

Yes, I have. No, I haven't. ⁵[Yes, my spouse has. No, my spouse hasn't.] ⁵[Yes, my dependent child(ren) have. No, my child(ren) haven't.]

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

Signature

- ¹[An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in the vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.]
- ²[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.]
- ³[I understand that my dependent(s) cannot be enrolled for a coverage, if I am not enrolled for that coverage.]
- ⁴[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
- 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.
- ⁵[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.]
- 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 ^{6A}[may deduct premiums from my pay] ^{6B}[apply premiums to my credit card or debit card,] or ^{6C}[add premiums to my dues,] if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

⁷[Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.]

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

⁷[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.)]

⁸[SIGNATURE OF EMPLOYEE X _____] DATE _____

Enrollment kit ## #### ###

1[Fraud Warning Statements

V

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.

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

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland 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.

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.]

SERFF Tracking Number: GARD-128518955 State: Arkansas
 Filing Company: The Guardian Life Insurance Company of America State Tracking Number:
 Company Tracking Number: 9664AR
 TOI: ML02 Multi-Line - Other Sub-TOI: ML02.000 Multi-Line - Other
 Product Name: CEF2012 Enrollment Form (Life & Health)
 Project Name/Number: 2012 Enrollment form /9664AR

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Name Change Endorsement	Approved-Closed	07/02/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Address Change Endorsement	Approved-Closed	07/02/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Variable Memorandum	Approved-Closed	07/02/2012
Comments:	see attached		
Attachment:	CEF2012 Variable Memorandum, v1 06-26-2012.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Redlined form and var. memo.	Approved-Closed	07/02/2012
Comments:			
Attachments:	CEF2012, dv1 06-25-2012 redline.pdf CEF2012 Variable Memorandum, v1 06-25-2012 redline.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Cert. of read.	Approved-Closed	07/02/2012

SERFF Tracking Number: GARD-128518955 *State:* Arkansas
Filing Company: The Guardian Life Insurance Company of *State Tracking Number:*
America
Company Tracking Number: 9664AR
TOI: ML02 Multi-Line - Other *Sub-TOI:* ML02.000 Multi-Line - Other
Product Name: CEF2012 Enrollment Form (Life & Health)
Project Name/Number: 2012 Enrollment form /9664AR

Comments:

Attachment:

Certification of Readability.pdf

Variable Memorandum Enrollment/Change Form – CEF2012

Variable material in enrollment form CEF2012 is outlined and may be changed, as explained below.

This form is an enrollment/change form used to enroll eligible employees/members of eligible groups. It is used when evidence of insurability may be required and contains health history 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/members only and may include pre-populated employee/member information.

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.

Plan Specific Options – Plan specific benefit options may be included based on plan design. For example, in some instances we may not include dollar amounts or percentages. Rather, we would only include the option to elect or waive coverage.

We reserve the right to make changes in format, design and presentation. For example, the form may appear in a landscape or portrait format. 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/members.

The terminology used to refer to “Employer” may be changed to “Policyholder”, or “Plan Administer” or “Channel Partner Name” and “Employee” to “Member”.

Premium amounts may be illustrated and will specify pay frequency.

All elements of this form may be translated into Spanish.

An internal identifier will appear in the lower right-hand corner of the form.

Section Number	Variables and Comments
A	<p>Company Name & Brand Logo</p> <p>(1) The Company Name may be changed to reflect the coverages being enrolled or include the name of the planholder’s administrator/channel partner. For example: The Guardian Brand Logo and/or the Brand Logo of subsidiary companies and/or planholder’s administrator/channel partner will be present when they are responsible for the coverages being sold to the eligible employee/member. Or, the issuing company(ies) name(s) will be changed or added to reflect a subsidiary company name if such a company provides dental coverage. The Company addresses may also be shown, as applicable, and are subject to change.</p> <p>(2) Either the address in (2A) or (2B) will be shown. The address may also reflect a planholder’s administrative office address (i.e. TPA address) or channel partner address.</p> <p>Form Name</p> <p>(3) Form Name may change based on type of usage (i.e. initial enrollment or change in enrollment status).</p>

Variable Memorandum Enrollment/Change Form – CEF2012

B	<p>Policyholder Section</p> <p>(1) Depending on the type of enrollment and/or type of coverage, some boxes may not appear. For example, if a new group is enrolling, only the Initial Enrollment box will appear.</p> <p>(2) Depending on the coverages selected Class, Division, and/or Subtotal Code may be deleted.</p> <p>(3) Depending on the business relationship, there may be an additional Group Plan Number. For example, "Channel Partner Name Plan Number" and/or "Plan Administrator Plan Number".</p>
C	<p>About You</p> <p>(1) Email Address and/or Phone number may be removed based on planholder request.</p>
D	<p>About Your Job</p> <p>(1) This section may be deleted in its entirety based on the type of group enrolling for coverage (i.e. members of an association).</p> <p>(2) Title may change based on type of group enrolling for coverage (i.e. "About Your Membership").</p> <p>(3) Specific items may be deleted if they are not applicable to the plan.</p> <p>(4) Annual Salary (Do not include bonus/commissions) may be removed if not applicable, or, instructions may be revised depending on the type of salary definition.</p> <p>(5) When retirees are not eligible to be enrolled, reference to retirees will be deleted.</p>
E	<p>About Your Family</p> <p>(1) Text will be deleted when this form is used for employees only, or when a coverage section is for employees only.</p> <p>(2) Depending on the type of coverage, some boxes may not appear.</p> <p>(3) State of Residence will be included if required by state law.</p>
F	<p>Drop Coverage/Coverage being Dropped/Loss of Other Coverage</p> <p>(1) Text will appear on Change Forms for dropping coverage.</p> <p>(2) Part of the text may be deleted when this form is used for non-employer type groups. Or, the term "Employment" may be replaced with "Membership" or the term "worked" may be replaced with "of membership" (i.e. "Last Day of Membership").</p> <p>(3) Coverages listed will be based on planholder coverage options. Additionally, spouse and child options will only appear if dependents were enrolled.</p> <p>(4) Text will only appear on Change Forms for adding employee/member or dependent coverage due to termination of employment, divorce, etc.</p> <p>(5) Dental and/or Vision may be removed based on plan options available.</p>
G	<p>Dental Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to "Dental Coverage" may change based on product design changes.</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Text will be deleted when this form is used for employees/member only, or when a coverage section is for employees/members only. The text may also be replaced with a tiered structure. (i.e. employee, employee & one dependent, and/or full family).</p> <p>(5) Plan specific benefit information will be included.</p> <p>(6) This text will only appear for DHMO plans. Plan specific information will appear.</p> <p>(7) The website address may change.</p> <p>(8) Waiver of coverage election boxes may be deleted.</p>

Variable Memorandum Enrollment/Change Form – CEF2012

H	<p>Vision Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Vision Coverage” may change based on product design changes.</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Text will be deleted when this form is used for employees/member only, or when a coverage section is for employees/members only. The text may also be replaced with a tiered structure. (i.e. employee, employee & one dependent, and/or full family).</p> <p>(5) Plan specific benefit information will be included.</p> <p>(6) Waiver of coverage election boxes may be deleted.</p>
I	<p>Dental Tied To Vision Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Dental Tied To Vision Coverage” may change based on product design changes.</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Text will be deleted when this form is used for employees/member only, or when a coverage section is for employees/members only. The text may also be replaced with a tiered structure. (i.e. employee, employee & one dependent, and/or full family).</p> <p>(5) Plan specific benefit information will be included.</p> <p>(6) This text will only appear for DHMO plans. Plan specific information will appear.</p> <p>(7) The website address may change.</p> <p>(8) Waiver of coverage election boxes may be deleted.</p>
J	<p>Dental Tied To Critical Illness Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Dental Tied To Critical Illness Coverage” may change based on product design changes.</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Insurance amounts may vary within the ranges of \$500 - \$25,000.</p> <p>(5) This text will only appear for DHMO plans. Plan specific information will appear.</p> <p>(6) The website address may change.</p> <p>(7) Waiver of coverage election boxes may be deleted.</p>

Variable Memorandum Enrollment/Change Form – CEF2012

K	<p>Basic Life Coverage With Accidental Death and Dismemberment (AD&D)</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Basic Life Coverage” or “Basic Life With Accidental Death and Dismemberment (AD&D) Coverage” may change based on product design changes. Or, the coverage title may change based on plan design (i.e. Basic Life Only or Basic Life With Accidental Death and Dismemberment (AD&D) Coverage).</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Either the text in (4A) or (4B) may be used if applicable. Language in (4A) will be used when the enrollment form is not personalized. Language in (4B) will be used when the enrollment form is personalized. Also, the age may vary. The age ranges are 60 to 90.</p> <p>(5) Percent of salary will vary within the ranges of 10% - 2,000%, but will not exceed the amount allowed by any applicable state law.</p> <p>(6) Insurance amounts may vary within the ranges of \$100 - \$9,999,999.</p> <p>(7) Percentage amounts may vary within the ranges of 5% - 100%.</p> <p>(8) Waiver of coverage election boxes may be deleted.</p> <p>Beneficiary Information</p> <p>(9) Will appear on form only when Basic Life with or without Accidental Death and Dismemberment (AD&D) Coverage is offered as part of the plan. This section may be replaced with different instructions if an alternative method is used for collecting beneficiary information, or may be removed in its entirety.</p> <p>(10) This text may be included based on state requirement.</p> <p>(11) This text may be deleted if someone other than the Employer maintains beneficiary information.</p> <p>(12) The Important Note may be removed.</p> <p>(13) Text may be included if required by state law.</p>
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Variable Memorandum Enrollment/Change Form – CEF2012

L	<p>Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D) Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Voluntary Term Life Coverage” or “Voluntary Term Life with Accidental Death and Dismemberment (AD&D) Coverage” may change based on product design changes. Or, the coverage title may change based on plan design (i.e. Voluntary Term Life Only or Voluntary Term Life With Accidental Death and Dismemberment (AD&D) Coverage).</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Either the text in (4A) or (4B) may be used if applicable. Language in (4A) will be used when the enrollment form is not personalized. Language in (4B) will be used when the enrollment form is personalized. Also, the age may vary. The age ranges are 60 to 90.</p> <p>(5) Policy Amounts may vary within the ranges of \$100 - \$9,999,999.</p> <p>(6) This text will be deleted if Guarantee Issue Amounts are not available, or if evidence of insurability is not required.</p> <p>(7) Percentage amounts may vary within the ranges of 5% - 100%.</p> <p>(8) Waiver of coverage election boxes may be deleted.</p> <p>(9) The tobacco question will appear when tobacco rates apply.</p> <p>(10) The time frame for the use of any form of tobacco may vary within the range of 3 months to 12 months; and the time frame for smoking cigarettes may vary within the range of 6 months to 24 months; but will never exceed that allowed by any applicable law.</p> <p>Beneficiary Information</p> <p>(11) Will appear on form only when Voluntary Term Life Coverage with or without Accidental Death and Dismemberment Coverage is offered as part of the plan. This section may be replaced with different instructions if an alternative method is used for collecting beneficiary information, or may be removed in its entirety.</p> <p>(12) Text will only appear if Basic Life and Voluntary Term Life coverages are offered.</p> <p>(13) The Important Note may be removed.</p> <p>(14) This text may be deleted if someone other than the Employer maintains beneficiary information.</p> <p>(15) Text may be included if required by state law.</p>
M	<p>Voluntary Accidental Death and Dismemberment Coverage (AD&D)</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Voluntary Accidental Death and Dismemberment (AD&D) Coverage” may change based on product design changes. Additionally, the term “Voluntary” may be replaced with the term “Optional”.</p> <p>(3) Policy Amounts may vary within the ranges of \$100 - \$9,999,999.</p> <p>(4) This text will be deleted if Guarantee Issue Amounts are not available, or if evidence of insurability is not required.</p> <p>(5) Text will be deleted when this form is used for employees only, or when a coverage section is for employees only.</p> <p>(6) Percentage amounts may vary within the ranges of 5% - 100%.</p> <p>(7) Maximum insurance amounts may vary within the ranges of \$95 - \$9,499,999.</p> <p>(8) Waiver of coverage election boxes may be deleted.</p>

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N	<p>Short-Term Disability Coverage (STD) and Long-Term Disability Coverage (LTD)</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to "Short-Term Disability (STD) Coverage" or "Long-Term Disability (LTD) Coverage" may change based on product design changes.</p> <p>(3) Percent of salary may range from 5% to 100%.</p> <p>(4) The STD maximum benefit amount ranges in (4A) may range from \$25 to \$9,000 per week. The LTD maximum benefit amount ranges in (4B) may range from \$25 to \$35,000 per month.</p> <p>(5) The reference to Buy-Up will be deleted if the Buy-Up option is not part of the plan.</p> <p>(6) "Core" terminology may be changed. For example, it could be "Traditional".</p> <p>(7) Waiver of coverage election boxes may be deleted.</p> <p>Short-Term and Long-Term Disability Coverage Questions</p> <p>(8) This section may appear based on the underwriting method or may be deleted if no Short-Term Disability or Long-Term Disability Coverage is offered as part of the plan.</p> <p>(9) The number of years may change and will vary from 6 months to 5 years.</p> <p>(10) The number of days may change and will vary from 5 to 45 days.</p> <p>(11) The number of missed days may change and can vary from 10 to 45 days.</p> <p>(12) The question may appear based on the type of underwriting method.</p>
O	<p>Multi-Coverage Plan</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to "Multi-Coverage Plan" may change based on product design changes.</p> <p>(3) Language may change to include "Spouse" and/or "Children" coverage.</p> <p>(4) Coverage amounts whether shown in dollars or percentages will vary based on coverage selected.</p> <p>(5) All options or any combination of options may be offered. Coverages may be removed depending on plan design.</p> <p>(6) Waiver of coverage election boxes may be deleted.</p> <p>(7) Important Note text will appear only when Critical Illness and/or Voluntary Term Life Coverage is offered as part of the plan and evidence of insurability is required. Or, the Important Note may be removed.</p>

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P	<p>Critical Illness Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to "Critical Illness Coverage" may change based on product design changes.</p> <p>(3) Text will be deleted when this form is used for employees only, or when a coverage section is for employees only.</p> <p>(4) Either the text in (4A) or (4B) will be used. Language in (4A) will be used when the enrollment form is not personalized. Language in (4B) will be used when the enrollment form is personalized. Also, the age may vary. The age ranges are 60 to 90.</p> <p>(5) Options will appear based on planholder selection. "Core" terminology may be changed. For example, it could be "Employee Option" or "Option 1".</p> <p>(6) Insurance amounts may vary within the ranges of \$500 - \$100,000. Text and number of options may vary based on plan design.</p> <p>(7) Waiver of coverage election boxes may be deleted.</p> <p>(8) Percentage amounts may vary within the ranges of 5% - 100%.</p> <p>(9) The tobacco question will appear when tobacco rates apply.</p> <p>(10) The time frame for the use of any form of tobacco may vary within the range of 3 months to 12 months; and the time frame for smoking cigarettes may vary within the range of 6 months to 24 months; but will never exceed that allowed by any applicable law.</p> <p>Critical Illness Coverage Questions</p> <p>(11) This sentence may be deleted if an Evidence of Insurability form is not required. Or, the text may be revised based on the type of underwriting method. For example, the text may change if no conditional issue amounts are offered or if guarantee issue amounts are available. And, actual dollar amounts may appear which will range from \$100 to \$100,000. Separate dollar amounts may appear for employee, spouse, and child.</p> <p>(12) 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.</p> <p>(13) The number of months for requiring a change in medication or dosage may vary from 3 months to 24 months.</p> <p>(14) The Important Note may be removed.</p>
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Variable Memorandum Enrollment/Change Form – CEF2012

Q	<p>Accident Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Accident Coverage” may change based on product design changes.</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Text will be deleted when this form is used for employees/member only, or when a coverage section is for employees/members only. The text may also be replaced with a tiered structure. (i.e. employee, employee & one dependent, and/or full family).</p> <p>(5) Plan specific benefit information will be included.</p> <p>(6) Waiver of coverage election boxes may be deleted.</p> <p>Beneficiary Information</p> <p>(7) Will appear on form only when Accident Coverage is offered as part of the plan. This section may be replaced with different instructions if an alternative method is used for collecting beneficiary information. The section will be removed if Accidental Death and Dismemberment Coverage is not part of the plan.</p> <p>(8) This text may be deleted if someone other than the Employer maintains beneficiary information.</p> <p>(9) Text may be included if required by state law.</p>
R	<p>Cancer Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Cancer Coverage” may change based on product design changes.</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Text will be deleted when this form is used for employees/member only, or when a coverage section is for employees/members only. The text may also be replaced with a tiered structure. (i.e. employee, employee & one dependent, and/or full family).</p> <p>(5) Plan specific benefit information will be included.</p> <p>(6) Waiver of coverage election boxes may be deleted.</p> <p>Cancer Coverage Questions</p> <p>(7) This section may be deleted in its entirety based on the type of underwriting method.</p> <p>(8) This sentence may be deleted if an Evidence of Insurability form is not required.</p> <p>(9) The 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.</p> <p>(10) The time frame may vary within the range of 2 to 20 years but will not exceed the time frame allowed by any applicable law.</p> <p>(11) This text may be deleted. Conditions may be added, deleted or changed as needed.</p>

Variable Memorandum Enrollment/Change Form – CEF2012

S	<p>Health History</p> <p>(1) This section will appear when Short-Term, Long-Term, Basic Life Insurance, and/or Voluntary Life Insurance, or any combinations of these coverages are being offered. Or, this section may be deleted in its entirety based on the type of underwriting method. And, upon request, this section may appear after the Short-Term, Long-Term, Basic Life Insurance, and/or Voluntary Life Insurance coverage section(s).</p> <p>(2) The terminology used to refer to the “Health History” section may change based on planholder request.</p> <p>(3) 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.</p> <p>(4) Text will be changed based on products being offered.</p> <p>(5) Text will be deleted when this form is used for employees only, or when a coverage section is for employees only.</p> <p>(6) The time frame may vary within the range of 3 to 24 months but will not exceed the time frame allowed by any applicable law.</p>
T	<p>Signature</p> <p>(1) This text will appear when Vision coverage is offered under the plan.</p> <p>(2) This text will appear when dependent Basic or Voluntary Life Coverage is offered under the plan.</p> <p>(3) This text will appear when dependent coverage is offered as part of the plan.</p> <p>(4) This text will only appear when premium amounts are included in the enrollment form.</p> <p>(5) This text will only appear when enrolling employer groups.</p> <p>(6) The text in (6A), (6B), or (6C), or any combination may appear.</p> <p>(7) The fraud warnings may be revised to comply with state requirements.</p> <p>(8) The signature may be replaced with an employee/member PIN (personal identification number) or digitized signature, depending on type of enrollment.</p>
U	<p>Enrollment Kit Number and Benefits Hotline</p> <p>(1) The Enrollment Kit Number may change or may not appear.</p> <p>(2) The benefits hotline name and telephone number may change or may not appear. Additionally, the website address may change or may not appear.</p>
V	<p>Fraud Warning Statements</p> <p>(1) The fraud warning statements page may be revised to comply with state requirements.</p>



The Guardian Life Insurance Company of America

And its Affiliates and Subsidiaries

-2A[Midwest Regional Office

-2B[Northeast Regional Office

P.O. Box 8012, Appleton, WI 54912-8012-1 P.O. Box 26050, Lehigh Valley, PA 18002-6050-1-11

A

23[Enrollment/Change Form]

Page 1 of X

Please print clearly and mark carefully.

Employer Name:	3[Group Plan Number: _____]	Benefits Effective:	B
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PLEASE CHECK APPROPRIATE BOX -1[] Initial Enrollment] 1[] Re-Enrollment] 1[] Add Employee/-Dependents] -1[] Drop/Refuse Coverage] 1[] Information Change]
 1[] Increase Amount] 1[] Family Status Change]

2[Class: _____] 2[Division: _____] 2[Subtotal Code: _____]
 _____ (Please obtain this from your _____ Employer)

About You: First, MI, Last Name: _____	Social Security Number _____ - _____ - _____	C
Address/City/State/Zip: _____		
Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth (mm-dd-yy): ____ - ____ - ____	1[Phone: () -]
1[Email Address:]	Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of marriage/union: ____ - ____ - ____
	Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Placement date of adopted child: ____ - ____ - ____

1[2[About Your Job:]	3[Hours worked per week: _____]	3[Job Title: _____]	D
3[Work] Status: 3[] Active] 5[] Retired] 3[] Cobra/State Continuation]	3[Date of full time hire: ____ - ____ - ____]	4[Annual Salary: \$ _____ Do not include bonus/commissions]	

1[About Your Family: Please include the names of the dependents you wish to enroll for coverage. 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.

Spouse (First, MI, Last Name)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) 2[] Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent] 3[State of Residence: _____]
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) 2[] Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent] 3[State of Residence: _____]
Child/Dependent 3:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) 2[] Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent] 3[State of Residence: _____]

Child/Dependent 4:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) ² <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent] ³ [State of Residence: _____]]
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¹ [Drop Coverage: <input type="checkbox"/> Drop Employee <input type="checkbox"/> Drop Dependents The date of withdrawal cannot be prior to the date this form is completed and signed. Last Day of Coverage ____ - ____ - ____ ² <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement] ² [Last Day worked: ____ - ____ - ____] <input type="checkbox"/> Other Event: _____ Date of Event: ____ - ____ - ____]	³ [Coverage Being Dropped: <input type="checkbox"/> Dental <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Vision <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Basic Life _____ <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) Child(ren) <input type="checkbox"/> AD&D <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Critical Illness <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Accident <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Cancer <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Short Term Disability I have been offered the above coverage(s) and wish to drop enrollment for the following reasons: <input type="checkbox"/> Covered under another insurance plan <input type="checkbox"/> Other _____ (additional information may be required)	⁴ [Loss Of Other Coverage: I and/or my dependents were previously covered under another group insurance plan. Loss of coverage was due to: ² <input type="checkbox"/> Termination of Employment: ____ - ____ - ____] <input type="checkbox"/> Divorce ____ - ____ - ____ <input type="checkbox"/> Death of Spouse ____ - ____ - ____ <input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____ Coverage Lost ⁵ <input type="checkbox"/> Dental] ⁵ <input type="checkbox"/> Vision]]	F
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¹ ² [Dental Coverage:] ³ [You must be enrolled to cover your dependents. Check only one box.] Employee Only ³⁴ [EE & Spouse] ³⁴ [EE & Dependent/Child(ren)] ³⁴ [EE, Spouse & Dependent/Child(ren)] ⁴⁵ [PPO] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ⁴⁵ [DHMO] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <ul style="list-style-type: none"> ⁵⁶[If ⁴⁵[Pre Paid/DHMO] is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit ⁶²[guardianlife.com] for a list of providers. If you do not select a PCD, one will be assigned for you. Employee _____ ³ [Spouse _____ Child(ren) _____]] ⁷⁸ <input type="checkbox"/> I do not want this coverage. If you do not want Dental Coverage, please mark all that apply: <input type="checkbox"/> I am covered under another Dental plan. <input type="checkbox"/> My spouse is covered under another Dental plan. <input type="checkbox"/> My dependents are covered under another Dental plan.]]	G
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¹ ² [Vision Coverage:] ³ [You must be enrolled to cover your dependents. Check only one box.] Employee Only ³⁴ [EE & Spouse] ³⁴ [EE & Dependent/Child(ren)] ³⁴ [EE, Spouse & Dependent/Child(ren)] ⁴⁵ [VSP] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ⁴⁵ [Davis Vision] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> ⁵⁶ <input type="checkbox"/> I do not want this coverage. If you do not want Vision Coverage, please mark all that apply: <input type="checkbox"/> I am covered under another Vision plan. <input type="checkbox"/> My spouse is covered under another Vision plan. <input type="checkbox"/> My dependents are covered under another Vision plan.]]	H
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I

¹²[Dental Tied To Vision Coverage:] ³[You must be enrolled to cover your dependents. Check only one box.]

When electing Dental coverage for (yourself ³[and/or your dependents] you also receive Vision Coverage.

Employee Only ³⁴[EE & Spouse] ³⁴[EE & Dependent/Child(ren)] ³⁴[EE, Spouse & Dependent/Child(ren)]

⁴⁵[PPO]

⁴⁵[MDG]

⁵⁶[If ⁴[Pre Paid/DHMO] is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit ⁶⁷[guardianlife.com] for a list of providers. If you do not select a PCD, one will be assigned for you.

Employee _____ ³[Spouse _____ Child(ren) _____]]

⁷⁸ I do not want this coverage. If you do not want this Coverage, please mark all that apply:

I am covered under another Dental plan Yes No Vision plan Yes No

My spouse is covered under another Dental plan Yes No Vision plan Yes No

My dependents are covered under another Dental plan Yes No Vision plan Yes No]]

J

¹²[Dental Tied To Critical Illness Coverage:] ³[You must be enrolled to cover your dependents. Check only one box.]

When electing dental (for yourself ³[and/or your dependents]) you also receive:

⁴[\$ _____] of Critical Illness coverage for yourself. ³ ⁴[\$ _____] of Critical Illness coverage for your spouse.]

³ ⁴[\$ _____] of Critical Illness coverage for your dependent children.]

Employee Only ³[EE & Spouse] ³[EE & Dependent/Child(ren)] ³[EE, Spouse & Dependent/Child(ren)]

- ⁵[If ⁴[Pre Paid /DHMO] is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit ⁶[guardianlife.com] for a list of providers. If you do not select a PCD, one will be assigned for you.

Employee _____ ³[Spouse _____ Child(ren) _____]]

⁷ I do not want this coverage. If you do not want this Coverage, please mark all that apply:

I am covered under another Dental plan.

My spouse is covered under another Dental plan.

My dependents are covered under another Dental plan.]]

K

¹²[Basic Life Coverage ²[With ⁴Accidental Death and Dismemberment (AD&D):] ³[You must be enrolled to cover your dependents. Check only one box.]

^{4A}[Benefit reductions apply. Please see plan administrator.] ^{4B}[Employees age 65+ Benefit reductions apply. Please see plan administrator.]

Policy Amount

Employee Only

⁵[200%] of your annual salary to maximum ⁶[\$9,999,999]

_____ ⁴[200%] of your annual salary to maximum ⁴[\$9,999,999]

⁸ I do not want this coverage.]

³[Spouse

⁶[\$5,000]

*-*The amount may not be more than ⁷[50%] of the employee amount]*

⁸ I do not want this coverage.]

³[Child/Dependent

⁶[\$2,500]

*-*The amount may not be more than ⁷[10%] of the employee amount.]*

⁸ I do not want this coverage.]

⁹[NAME YOUR BENEFICIARIES (primary beneficiary percentages must total 100

Primary Beneficiaries:

Name _____

Relationship to employee: _____

Name _____

Relationship to employee: _____

Contingent Beneficiary:

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~~(In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)~~

~~¹⁰[If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy. \$ _____]~~

Important Notes:

- ~~• Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Basic Life.~~

L

¹~~[Voluntary Term Life Coverage]~~ With ²~~[Accidental Death and Dismemberment (AD&D)]~~ — ³~~[You must be enrolled to cover your dependents. Check only one box.]~~

^{4A}~~[Benefit reductions apply. Please see plan administrator.]~~ ^{4B}~~[Employees age 65+ Benefit reductions apply. Please see plan administrator.]~~

Policy Amount — Check one box only.

⁵[\$25,000] ⁵[\$50,000] ⁵[\$75,000] ⁵[\$100,000*] ⁵[\$150,000**]

⁶~~[*Guarantee Issue Amount~~

~~**Guarantee Issue Amount plus Additional Amount]~~

³~~[Add Voluntary Life for Spouse~~

⁷[50%] of employee's amount to maximum ⁵[\$50,000] * ~~The amount may not be more than ⁷[50%] of the employee amount for Voluntary Life.]~~

⁸ ~~I do not want this coverage.]~~

¹⁰~~[If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy. \$ _____] ³~~[Add Voluntary Life for Dependent/Child(ren)~~~~

⁷[10%] of employee's amount to maximum ⁵[\$10,000] * ~~The amount may not be more than ⁷[10%] of the employee amount for Voluntary Life.]~~

⁸ ~~I do not want this coverage.]~~

⁹~~[Have you used any form of tobacco in the past ¹⁰[6] months (e.g. pipe, chewing tobacco) and/or have you smoked cigarettes in the past ¹⁰[12] months?~~

Employee Yes No — ³~~[Spouse Yes No]]~~

¹²Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for ~~Voluntary~~ Basic Life.]

¹¹~~[Name your beneficiaries: (primary beneficiary percentages must total 100%) — ¹²[If electing different beneficiaries that are not the same as those named for Basic Life, please name below.]~~

Primary Beneficiaries:

Name: _____ % _____

Name: _____ ¹³[Social Security Number: _____ - _____ - _____] % _____

¹³[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ¹³[Address/City/State/Zip: _____]

¹³[Phone: () - _____] Relationship to employee: _____

Name: _____ % _____

Name: _____ ¹³[Social Security Number: _____ - _____ - _____] % _____

¹³[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ¹³[Address/City/State/Zip: _____]

¹³[Phone: () - _____] Relationship to employee: _____

Contingent Beneficiary: _____ Name: _____

¹³[Social Security Number: _____ - _____ - _____]

¹³[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ¹³[Address/City/State/Zip: _____]

¹³[Phone: () - _____] Relationship to employee: _____

(In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. ¹¹~~[Employer maintains beneficiary information.]~~)

_____)]]

M

¹~~[Voluntary Term Life Coverage]~~ ²~~[With [Accidental Death and Dismemberment (AD&D) Coverage:] — ⁵]~~ ³~~[You must be enrolled to cover your dependents. Check only one box]~~

^{4A}~~[Benefit reductions apply. Please see plan administrator.]~~ ^{4B}~~[Employees age 65+ Benefit reductions apply. Please see plan administrator.]~~

Policy Amount Check one box only.

⁵[\$25,000] ⁵[\$50,000] ⁵[\$75,000] ⁵[\$100,000*] ⁵[\$150,000**]

⁶*Guarantee Issue Amount

^{**}Guarantee Issue Amount plus Additional Amount

⁸ I do not want this coverage.

³Add Voluntary Life for Spouse

⁷[50%] of employee's amount to maximum ⁵[\$50,000]

^{*}The amount may not be more than ⁷[50%] of the employee amount for Voluntary Life.

⁶Spouse Guarantee Issue amount : ⁵[\$50,000]

⁸ I do not want this coverage.

³Add Voluntary Life for Dependent/Child(ren)

⁷[10%] of employee's amount to maximum

⁵[\$10,000] ^{*}The amount may not be more than ⁷[10%] of the employee amount for Voluntary Life.

⁶Child Guarantee Issue amount: ⁵[\$10,000]

⁸ I do not want this coverage.

⁹Have you used any form of tobacco in the past ¹⁰[6] months (e.g. pipe, chewing tobacco) and/or have you smoked cigarettes in the past ¹⁰[12] months?

Employee Yes No ³Spouse Yes No]]

¹³Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.]]

¹¹[Name your beneficiaries: (primary beneficiary percentages must total 100%) ¹²[If electing different beneficiaries that are not the same as those named for Basic Life, please name below.]

Primary Beneficiaries:

Name: _____ ¹⁵[Social Security Number: _____ - _____ - _____] % _____

¹⁵[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ¹⁵[Address/City/State/Zip: _____]

¹⁵[Phone: () _____ - _____] Relationship to employee: _____

Name: _____ ¹⁵[Social Security Number: _____ - _____ - _____] % _____

¹⁵[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ¹⁵[Address/City/State/Zip: _____]

¹⁵[Phone: () _____ - _____] Relationship to employee: _____

Contingent Beneficiary Name: _____ ¹⁵[Social Security Number: _____ - _____ - _____]

¹⁵[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ¹⁵[Address/City/State/Zip: _____]

¹⁵[Phone: () _____ - _____] Relationship to employee: _____

(In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. ¹⁴[Employer maintains beneficiary information.])

¹²[Voluntary Accidental Death and Dismemberment (AD&D) Coverage:] ⁵[You must be enrolled to cover your dependents. Check only one box.]

M

**Employee Only
Policy Amount**

Check only one box.

³[\$25,000] ³[\$50,000] ³[\$75,000]

³[\$100,000] ³**\$150,000]

⁴[*Guarantee Issue Amount]

⁴[**Guarantee Issue Amount plus Additional Amount]

⁸[I do not want this coverage.]

⁵[Spouse

Check only one box.

⁶[50%] of employee's amount to a maximum of ⁷[\$50,000].

*The amount may not be more than ⁶[50%] of the employee amount for Voluntary Life.]

⁸[I do not want this coverage.]

⁵[Child(ren)

Check only one box.

⁶[10%] of employee's amount to a maximum of ⁷[\$10,000.]

*The amount may not be more than ⁶[10%] of the employee amount for Voluntary Life.]

⁸[I do not want this coverage.]

¹ ² [Short -Term Disability (STD) Coverage:] ⁶ [Core] Weekly Benefit <input type="checkbox"/> ³ [60%] of salary to a maximum of ^{4A} [\$250] ⁷ <input type="checkbox"/> I do not want this coverage.]	⁵ [Buy-Up Option 1 <i>Weekly Benefit</i> <input type="checkbox"/> ³ [60%] of salary to a maximum of ^{4A} [\$500] ⁷ <input type="checkbox"/> I do not want this coverage.]]	⁵ [Buy-Up Option 2 <i>Weekly Benefit</i> <input type="checkbox"/> ³ [60%] of salary to a maximum of ^{4A} [\$700] ⁷ <input type="checkbox"/> I do not want this coverage.]]	N
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¹ ² [Long-Term Disability (LTD) Coverage-:] ⁶ [Core] <i>Monthly benefit</i> <input type="checkbox"/> ³ [60%] of salary to a maximum of ^{4B} [\$5,000] ⁷ <input type="checkbox"/> I do not want this coverage.]]	⁵ [Buy Up <i>Monthly Benefit</i> <input type="checkbox"/> ³ [____ %] of salary to a maximum of ^{4B} [\$ _____] ⁷ <input type="checkbox"/> I do not want this coverage.]]
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⁸[Complete if you are enrolling for employee-paid ⁸[STD] and/or ⁸[LTD] Coverage.
 In the past ⁹[two] years, have you missed ¹⁰[5] or more consecutive work days for a sickness, injury or chronic condition other than a cold or flu? Yes No
 In the past ⁹[two] years, have you missed more than ¹¹[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. _____
¹²[Are you currently pregnant? Yes No Does not apply]
 You must complete an Evidence of Insurability Form if you answered "Yes" to any of the above questions.]

¹ ² [Multi-Coverage Plan:] <input type="checkbox"/> I elect ³ [Employee] Coverage ⁴ [\$ _____] ⁵ [Voluntary Term Life Insurance] ⁴ [\$ _____] ⁵ [Voluntary AD&D insurance] ⁴ [\$ _____] ⁵ [per Month Long Term Disability Income Insurance (max of 66 2/3% of salary)] ⁴ [\$ _____] ⁵ [per Week Short Term Disability Income Insurance (max of 66 2/3% of salary)] ⁴ [\$ _____] ⁵ [Critical Illness Insurance] ⁵ [Dental Coverage] <u>⁵[Accident]</u> ⁵ [Vision Coverage] <u> </u> ⁵ [Cancer] ⁶ <input type="checkbox"/> I do not want this coverage.]]	O
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⁷[Important Notes:
 • Based on your plan benefits and age, you may be required to complete an evidence of insurability form for [Critical Illness and Voluntary Term Life].]

¹²[Critical Illness Coverage:] ³[You must be enrolled to cover your dependents.]

^{4A}[Benefit reductions apply. Please see plan administrator.] ^{4B}[Employees age 65+ Benefit reductions apply. Please see plan administrator]

⁴⁵[Core Insurance Amount : ⁵⁴[\$500] ⁵⁴[\$5,000] ⁵⁴[\$10,000] ⁵⁴[\$25,000] ⁶⁷[I do not want this coverage.]]

⁴⁵[Buy up Insurance Amount: ⁵⁴[\$50,000] ⁶⁷[I do not want this coverage.]]

⁴⁵[Spouse Insurance Amount ⁵⁴[\$25,000] ⁶The amount may not be more than ⁸[50%] of Employee Amount ⁷[I do not want this coverage.]]

⁴⁵[Dependent/Child(ren) Insurance Amount: ⁵⁴[\$5,000] The amount may not be more than ⁸[50%] of Employee Amount. ⁶⁷[I do not want this coverage.]]

⁷⁹[Have you used any form of tobacco in the past ⁸¹⁰[6] months (e.g. pipe, chewing tobacco) and/or have you smoked cigarettes in the past ⁸¹⁰[12] months? Employee Yes No ²[Spouse Yes No]]

⁹¹¹[If you ³[or your dependent spouse or dependents] elect ²[Critical Illness Coverage], you must answer the following health questions.]

¹⁰¹²[1. Has any proposed insured been diagnosed with or treated for any of the following conditions: ¹⁰¹²[cancer], ¹⁰¹²[carcinoma in situ], ¹⁰¹²[malignant melanoma], ¹⁰¹²[any chronic or progressive disease of heart], ¹⁰¹²[kidneys], ¹⁰¹²[liver], ¹⁰¹²[lungs], ¹⁰¹²[pancreas] or ¹⁰¹²[bone marrow]? Or, been advised to have an ¹⁰¹²[organ transplant], including ¹⁰¹²[bone marrow] or ¹⁰¹²[stem cell transplant]?

Employee Yes No ³[Spouse Yes No Dependent Child(ren) Yes No]

2. Has the proposed insured been diagnosed with or treated for: ¹⁰¹²[heart attack] or ¹⁰¹²[heart disease], ¹⁰¹²[stroke] or ¹⁰¹²[transient ischemic attack (TIA)], or been advised to have ¹⁰¹²[bypass surgery], ¹⁰¹²[stent insertions] ¹⁰¹²[treatment for coronary arteries]?

Employee Yes No ³[Spouse Yes No Dependent Child(ren) Yes No]

3. Has the proposed insured been diagnosed with or treated for ¹⁰¹²[uncontrolled blood pressure] (requiring a change in medication or dosage in the past ¹¹²[6] months) or been diagnosed with or treated for ¹⁰¹²[diabetes] (except if present only in pregnancy) Employee Yes No ³[Spouse Yes No Dependent Child(ren) Yes No]]

¹⁴[Important Notes:

- Based on your plan benefits and age you may be required to complete an additional evidence of insurability form for Critical Illness.]
- .]]

¹ ²[Accident Coverage]: ³[You must be enrolled to cover your dependents. Check only one box.]

	Employee Only	⁴ [EE & Spouse]	⁴ [EE & Dependent/Child(ren)]	⁴ [EE, Spouse & Dependent/Child(ren)]
⁵ [Value Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
⁵ [Advantage Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
⁵ [Premier Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

⁶[I do not want this coverage.] ⁶[I do not want this coverage.] ⁶[I do not want this coverage.] ⁶[I do not want this coverage.]

⁷[Name your beneficiaries: (Primary beneficiary percentages must total 100%)]

Primary Beneficiaries:

Name: _____ ⁹[Social Security Number: _____ - _____ - _____] %
⁹[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ⁹[Address/City/State/Zip: _____]
⁹[Phone: (_____) - _____] Relationship to employee: _____

Name: _____ ⁹[Social Security Number: _____ - _____ - _____] %
⁹[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ⁹[Address/City/State/Zip: _____]
⁹[Phone: (_____) - _____] Relationship to employee: _____

Contingent Beneficiary Name: _____ ⁹[Social Security Number: _____ - _____ - _____]
⁹[Date of Birth: Date of Birth (mm-dd-yy): _____ - _____ - _____] ⁹[Address/City/State/Zip: _____]

⁹[Phone: () -] Relationship to employee: _____

(In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. ⁸[Employer maintains beneficiary information.])

¹ ²[Cancer Coverage:] ³[You must be enrolled to cover your dependents. Check only one box.]

R
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	Employee Only	⁴ [EE & Spouse]	⁴ [EE & Dependent/Child(ren)]	⁴ [EE, Spouse & Dependent/Child(ren)]
⁵ [Value Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
⁵ [Advantage Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
⁵ [Premier Plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

⁶[I do not want this coverage.] ⁶[I do not want this coverage.] ⁶[I do not want this coverage.] ⁶[I do not want this coverage.]

⁷[Complete the following question if you are enrolling for Cancer coverage. ⁸[NOTE: Additional information may be required.]

Has anyone to be covered been treated for or diagnosed as having ⁹[Cancer in any form] ¹¹[except non melanoma skin cancer], a ⁹[pre-leukemic condition], ⁹[a pre-malignant condition or a condition with malignant potential:] ¹¹[(such as colon polyps or pre-cancerous moles)] ¹¹[(except colon polyps and pre-cancerous moles)] ⁹[the following pre-malignant conditions or conditions with malignant potential: (i) colon polyps: (ii) pre-cancerous moles], ⁹[Acquired Immune Deficiency Syndrome (AIDS)] or ⁹[AIDS Related Complex (ARC)] within the last ¹⁰[10] years?

Yes, I have. No, I haven't. ³[Yes, my spouse has. No, my spouse hasn't.] ³[Yes, my dependent child(ren) have. No, my child(ren) haven't.]

¹ ²[Health History:]

e
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Complete the following question if you are enrolling for one or more of the following benefits listed below. NOTE: Additional information may be required.

⁴[Short Term Disability] ⁴[Long Term Disability] ⁴[Basic Life Insurance] ⁴[Voluntary Life Insurance]

³[In the last ⁶[6] months have you ⁵[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: ³[Cancer], ³[Heart Disease], ³[Diabetes]; any condition related to ³[Acquired Immune Deficiency Disorder (AIDS)] or ³[AIDS Related Complex]; or any other Chronic Condition?]

Yes, I have. No, I haven't. ⁵[Yes, my spouse has. No, my spouse hasn't.] ⁵[Yes, my dependent child(ren) have. No, my child(ren) haven't.]

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

Signature

- 1[An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in the vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.]
- 2[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.]
- 3[I understand that my dependent(s) cannot be enrolled for a coverage, if I am not enrolled for that coverage.]
- 4[I understand that the premium amounts shown above are estimations and are for illustrative purposes only.]
- ~~5A[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.]~~ 5B[You must be legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.]
- 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
- 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.
- 5[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.]
- 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 6A[may deduct premiums from my pay] 6B[apply premiums to my credit card or debit card.] or 6C[add premiums to my dues.] if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of Guardian applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing Guardian thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

62[Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.]

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

62[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.)]

78[SIGNATURE OF EMPLOYEE X _____] DATE _____

Enrollment kit ## #### ##



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~~CEF2011~~ CEF2012

Helpline² [(888) 600-1600]

² [www.guardianlife.com]

[[dv1, 06-25-2012](#)]

[GG-xxxxxx]

Questions? Call the Guardian

¹[Fraud Warning Statements

V

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.

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

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland 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.

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.]

Variable Memorandum Enrollment/Change Form – ~~CEF2011~~ CEF2012

Variable material in enrollment form CEF2012⁴ is outlined and may be changed, as explained below.

This form is an enrollment/change form used to enroll eligible employees/members of eligible groups. It is used when evidence of insurability may be required and contains health history 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/members only and may include pre-populated employee/member information.

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.

Plan Specific Options – Plan specific benefit options may be included based on plan design. For example, in some instances we may not include dollar amounts or percentages. Rather, we would only include the option to elect or waive coverage.

We reserve the right to make changes in format, design and presentation. For example, the form may appear in a landscape or portrait format. 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/members.

The terminology used to refer to “Employer” may be changed to “Policyholder”, or “Plan Administer” or “Channel Partner Name” and “Employee” to “Member”.

Premium amounts may be illustrated and will specify pay frequency.

All elements of this form may be translated into Spanish.

An internal identifier will appear in the lower right-hand corner of the form.

Section Number	Variables and Comments
A	<p>Company Name & Brand Logo</p> <p><u>(1)</u> The Company Name may be changed to reflect the coverages being enrolled <u>or include the name of the planholder’s administrator/channel partner</u>. For example: The Guardian Brand Logo and/or the Brand Logo of subsidiary companies <u>and/or planholder’s administrator/channel partner</u> will be present when they are responsible for the coverages being sold to the eligible employee/member. Or, the issuing company(ies) name(s) will be changed or added to reflect a subsidiary company name if such a company provides dental coverage. The Company addresses may also be shown, as applicable, and are subject to change.</p> <p>(1)<u>(2)</u> <u>Either the address in (2A) or (2B) will be shown. The address may also reflect a planholder’s administrative office address (i.e. TPA address) or channel partner address.</u></p> <p>Form Name</p> <p>(2)<u>(3)</u> Form Name may change based on type of usage (i.e. initial enrollment or change in enrollment status).</p>

Variable Memorandum Enrollment/Change Form – ~~CEF2011~~ CEF2012

B	<p>Policyholder Section</p> <p>(1) Depending on the type of enrollment <u>and/or type of coverage</u>, some boxes may not appear. For example, if a new group is enrolling, only the Initial Enrollment box will appear.</p> <p>(2) Depending on the coverages selected Class, Division, and/or Sub-Total <u>total</u> Code may be deleted.</p> <p>(2)(3) <u>Depending on the business relationship, there may be an additional Group Plan Number. For example, "Channel Partner Name Plan Number" and/or "Plan Administrator Plan Number".</u></p>
C	<p>About You</p> <p>(1) Email Address and/or Phone number may be removed based on planholder request.</p>
D	<p>About Your Job</p> <p>(1) <u>This section may be deleted in its entirety based on the type of group enrolling for coverage (i.e. members of an association).</u></p> <p>(1)(2) <u>Title may change based on type of group enrolling for coverage (i.e. "About Your Membership").</u></p> <p>(2)(3) <u>Specific items Text may be deleted when this form is used for enrolling members of an association if they are not applicable to the plan.</u></p> <p>(3)(4) Annual Salary (Do not include bonus/commissions) may be removed if not applicable, or, instructions may be revised depending on the type of salary definition.</p> <p>(4)(5) When retirees are not eligible to be enrolled, reference to retirees will be deleted.</p>
E	<p>About Your Family</p> <p>(1) Text will be deleted when this form is used for employees only, or when a coverage section is for employees only.</p> <p>(2) Depending on the type of coverage, some boxes may not appear.</p> <p>(3) State of Residence will be included if required by state law.</p>
F	<p>Drop Coverage/Coverage being Dropped/Loss of Other Coverage</p> <p>(1) Text will appear on Change Forms for dropping coverage.</p> <p>(2) <u>Part of the Text text may be deleted when this form is used by members of an association for non-employer type groups. Or, the term "Employment" may be replaced with "Membership" or the term "worked" may be replaced with "of membership" (i.e. "Last Day of Membership").</u></p> <p>(3) Coverages listed will be based on planholder coverage options. Additionally, spouse and child options will only appear if dependents were enrolled.</p> <p>(4) Text will only appear on Change Forms for adding employee/member or dependent coverage due to termination of employment, divorce, etc.</p> <p>(5) Dental and/or Vision may be removed based on plan options available.</p>
G	<p>Dental Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to "Dental Coverage" may change based on product design changes.</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(3)(4) <u>Text will be deleted when this form is used for employees/member only, or when a coverage section is for employees/members only. The text may also be replaced with a tiered structure. (i.e. employee, employee & one dependent, and/or full family).</u></p> <p>(4)(5) Plan specific benefit information will be included.</p> <p>(5)(6) This text will only appear for DHMO plans. Plan specific information will appear.</p> <p>(6)(7) The website address may change.</p> <p>(7)(8) Waiver of coverage election boxes may be deleted.</p>

Variable Memorandum
Enrollment/Change Form – ~~CEF2011~~CEF2012

H	<p>Vision Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Vision Coverage” may change based on product design changes.</p> <p>(3) <u>(3)</u> Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(3)(4) <u>(4)</u> Text will be deleted when this form is used for employees/member only, or when a coverage section is for employees/members only. The text may also be replaced with a tiered structure. (i.e. employee, employee & one dependent, and/or full family).</p> <p>(4)(5) <u>(5)</u> Plan specific benefit information will be included.</p> <p>(5)(6) <u>(6)</u> Waiver of coverage election boxes may be deleted.</p>
I	<p>Dental Tied To Vision Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Dental Tied To Vision Coverage” may change based on product design changes.</p> <p>(3) <u>(3)</u> Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(3)(4) <u>(4)</u> Text will be deleted when this form is used for employees/member only, or when a coverage section is for employees/members only. The text may also be replaced with a tiered structure. (i.e. employee, employee & one dependent, and/or full family).</p> <p>(4)(5) <u>(5)</u> Plan specific benefit information will be included.</p> <p>(5)(6) <u>(6)</u> This text will only appear for DHMO plans. Plan specific information will appear.</p> <p>(6)(7) <u>(7)</u> The website address may change.</p> <p>(7)(8) <u>(8)</u> Waiver of coverage election boxes may be deleted.</p>
J	<p>Dental Tied To Critical Illness Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Dental Tied To Critical Illness Coverage” may change based on product design changes.</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Insurance amounts may vary within the ranges of \$500 - \$25,000.</p> <p>(5) This text will only appear for DHMO plans. Plan specific information will appear.</p> <p>(6) The website address may change.</p> <p>(7) Waiver of coverage election boxes may be deleted.</p>

Variable Memorandum
Enrollment/Change Form – ~~CEF2011~~CEF2012

K	<p>Basic Life Coverage With Accidental Death and Dismemberment (AD&D)</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Basic Life Coverage” or “Basic Life With Accidental Death and Dismemberment (AD&D) Coverage” may change based on product design changes. Or, the coverage title may change based on plan design (i.e. Basic Life Only or Basic Life With Accidental Death and Dismemberment (AD&D) Coverage).</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Either the text in (4A) or (4B) will <u>may</u> be used <u>if applicable</u>. Language in (4A) will be used when the enrollment form is not personalized. Language in (4B) will be used when the enrollment form is personalized. Also, the age may vary. The age ranges are 60 to 90.</p> <p>(5) Percent of salary will vary within the ranges of 10% - 2,000%, but will not exceed the amount allowed by any applicable state law.</p> <p>(6) Insurance amounts may vary within the ranges of \$100 - \$9,999,999.</p> <p>(7) Percentage amounts may vary within the ranges of 5% - 100%.</p> <p>(8) Waiver of coverage election boxes may be deleted.</p> <p>Beneficiary Information</p> <p>(9) Will appear on form only when Basic Life with or without Accidental Death and Dismemberment (AD&D) Coverage is offered as part of the plan. This section may be replaced with different instructions if an alternative method is used for collecting beneficiary information, <u>or may be removed in its entirety</u>.</p> <p><u>(10)</u> This text may be included based on state requirement.</p> <p><u>(11)</u> <u>This text may be deleted if someone other than the Employer maintains beneficiary information.</u></p> <p><u>(12)</u> <u>The Important Note may be removed.</u></p> <p>(10)<u>(13)</u> <u>Text may be included if required by state law.</u></p>
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Variable Memorandum
Enrollment/Change Form – ~~CEF2011~~ CEF2012

L	<p>Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D) Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Voluntary Term Life Coverage” or “Voluntary Term Life with Accidental Death and Dismemberment (AD&D) Coverage” may change based on product design changes. Or, the coverage title may change based on plan design (i.e. Voluntary Term Life Only or Voluntary Term Life With Accidental Death and Dismemberment (AD&D) Coverage).</p> <p>(3) Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</p> <p>(4) Either the text in (4A) or (4B) will <u>may</u> be used <u>if applicable</u>. Language in (4A) will be used when the enrollment form is not personalized. Language in (4B) will be used when the enrollment form is personalized. Also, the age may vary. The age ranges are 60 to 90.</p> <p>(5) Policy Amounts may vary within the ranges of \$100 - \$9,999,999.</p> <p>(6) This text will be deleted if Guarantee Issue Amounts are not available, <u>or if evidence of insurability is not required</u>.</p> <p>(7) Percentage amounts may vary within the ranges of 5% - 100%.</p> <p>(8) Waiver of coverage election boxes may be deleted.</p> <p>(9) The tobacco question will appear when tobacco rates apply.</p> <p>(10) The time frame for the use of any form of tobacco may vary within the range of 3 months to 12 months; and the time frame for smoking cigarettes may vary within the range of 6 months to 24 months; but will never exceed that allowed by any applicable law.</p> <p>Beneficiary Information</p> <p>(11) Will appear on form only when Voluntary Term Life Coverage with or without Accidental Death and Dismemberment Coverage is offered as part of the plan. This section may be replaced with different instructions if an alternative method is used for collecting beneficiary information, <u>or may be removed in its entirety</u>.</p> <p><u>(12) Text will only appear if Basic Life and Voluntary Term Life coverages are offered.</u></p> <p><u>(13) The Important Note may be removed.</u></p> <p><u>(14) This text may be deleted if someone other than the Employer maintains beneficiary information.</u></p> <p>(14) <u>(15) Text may be included if required by state law.</u></p>
M	<p>Voluntary Accidental Death and Dismemberment Coverage (AD&D)</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to “Voluntary Accidental Death and Dismemberment (AD&D) Coverage” may change based on product design changes. <u>Additionally, the term “Voluntary” may be replaced with the term “Optional”.</u></p> <p>(3) Policy Amounts may vary within the ranges of \$100 - \$9,999,999.</p> <p>(4) This text will be deleted if <u>Guarantee Issue Amounts are not available, or if there is no</u> evidence of insurability <u>is not</u> required.</p> <p>(5) Text will be deleted when this form is used for employees only, or when a coverage section is for employees only.</p> <p>(6) Percentage amounts may vary within the ranges of 5% - 100%.</p> <p>(7) Maximum insurance amounts may vary within the ranges of \$95 - \$9,499,999.</p> <p>(8) Waiver of coverage election boxes may be deleted.</p>

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N	<p>Short-Term Disability Coverage (STD) and Long-Term Disability Coverage (LTD)</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to "Short-Term Disability (STD) Coverage" or "Long-Term Disability (LTD) Coverage" may change based on product design changes.</p> <p>(3) Percent of salary may range from 5% to 100%.</p> <p>(4) The STD maximum benefit amount ranges in (4A) may range from \$25 to \$9,000 per week. The LTD maximum benefit amount ranges in (4B) may range from \$25 to \$35,000 per month.</p> <p>(5) The reference to Buy-Up will be deleted if the Buy-Up option is not part of the plan.</p> <p>(6) "Core" terminology may be changed. For example, it could be "Traditional".</p> <p>(7) Waiver of coverage election boxes may be deleted.</p> <p>Short-Term and Long-Term Disability Coverage Questions</p> <p>(8) This section may appear based on the underwriting method or may be deleted if no Short-Term Disability or Long-Term Disability Coverage is offered as part of the plan.</p> <p><u>(9) The number of years may change and will vary from 6 months to 5 years.</u></p> <p>(9)(10) The number of days may change and will vary from 5 to 45 days.</p> <p>(10)(11) The number of missed days may change and can vary from 10 to 45 days.</p> <p>(11)(12) The question may appear based on the type of underwriting method.</p>
O	<p>Multi-Coverage Plan</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to "Multi-Coverage Plan" may change based on product design changes.</p> <p>(3) Language may change to include "Spouse" <u>and/or "Children"</u> coverage.</p> <p>(4) Coverage amounts whether shown in dollars or percentages will vary based on coverage selected.</p> <p>(5) All options or any combination of options may be offered. Coverages may be removed depending on plan design.</p> <p>(6) Waiver of coverage election boxes may be deleted.</p> <p>(7) Important Note text will appear only when Critical Illness and/or Voluntary Term Life Coverage is offered as part of the plan <u>and evidence of insurability is required. Or, the Important Note may be removed.</u></p>

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P	<p>Critical Illness Coverage</p> <p>(1) This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</p> <p>(2) The terminology used to refer to "Critical Illness Coverage" may change based on product design changes.</p> <p>(3) Text will be deleted when this form is used for employees only, or when a coverage section is for employees only.</p> <p><u>(4)</u> <u>Either the text in (4A) or (4B) will be used. Language in (4A) will be used when the enrollment form is not personalized. Language in (4B) will be used when the enrollment form is personalized. Also, the age may vary. The age ranges are 60 to 90.</u></p> <p>(4)<u>(5)</u> Options will appear based on planholder selection. "Core" terminology may be changed. For example, it could be "Employee Option" or "Option 1".</p> <p>(5)<u>(6)</u> Insurance amounts may vary within the ranges of \$500 - \$100,000. Text and number of options may vary based on plan design.</p> <p>(6)<u>(7)</u> Waiver of coverage election boxes may be deleted.</p> <p><u>(8)</u> <u>Percentage amounts may vary within the ranges of 5% - 100%.</u></p> <p>(7)<u>(9)</u> The tobacco question will appear when tobacco rates apply.</p> <p>(8)<u>(10)</u> The time frame for the use of any form of tobacco may vary within the range of 3 months to 12 months; and the time frame for smoking cigarettes may vary within the range of 6 months to 24 months; but will never exceed that allowed by any applicable law.</p> <p>Critical Illness Coverage Questions</p> <p>(9)<u>(11)</u> This sentence may be deleted if an Evidence of Insurability form is not required. Or, the text may be revised based on the type of underwriting method. For example, the text may change if no conditional issue amounts are offered or if guarantee issue amounts are available. And, actual dollar amounts may appear which will range from \$100 to \$100,000. Separate dollar amounts may appear for employee, spouse, and child.</p> <p>(10)<u>(12)</u> 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.</p> <p><u>(13)</u> The number of months for requiring a change in medication or dosage may vary from 3 months to 24 months.</p> <p>(11)<u>(14)</u> <u>The Important Note may be removed.</u></p>
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<u>Q</u>	<p><u>Accident Coverage</u></p> <p>(1) <u>This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</u></p> <p>(2) <u>The terminology used to refer to “Accident Coverage” may change based on product design changes.</u></p> <p>(3) <u>Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</u></p> <p>(4) <u>Text will be deleted when this form is used for employees/member only, or when a coverage section is for employees/members only. The text may also be replaced with a tiered structure. (i.e. employee, employee & one dependent, and/or full family).</u></p> <p>(5) <u>Plan specific benefit information will be included.</u></p> <p>(6) <u>Waiver of coverage election boxes may be deleted.</u></p> <p><u>Beneficiary Information</u></p> <p>(7) <u>Will appear on form only when Accident Coverage is offered as part of the plan. This section may be replaced with different instructions if an alternative method is used for collecting beneficiary information. The section will be removed if Accidental Death and Dismemberment Coverage is not part of the plan.</u></p> <p>(8) <u>This text may be deleted if someone other than the Employer maintains beneficiary information.</u></p> <p>(9) <u>Text may be included if required by state law.</u></p>
<u>R</u>	<p><u>Cancer Coverage</u></p> <p>(1) <u>This section may be deleted depending on coverage being offered. Or, this section, along with other coverage sections may appear in a different order. Additionally, specifications may change to reflect changes in product design. And, plan specific benefit information may be included.</u></p> <p>(2) <u>The terminology used to refer to “Cancer Coverage” may change based on product design changes.</u></p> <p>(3) <u>Text will be deleted when this form is used for employees/members only, or when a coverage section is for employees/members only.</u></p> <p>(4) <u>Text will be deleted when this form is used for employees/member only, or when a coverage section is for employees/members only. The text may also be replaced with a tiered structure. (i.e. employee, employee & one dependent, and/or full family).</u></p> <p>(5) <u>Plan specific benefit information will be included.</u></p> <p>(6) <u>Waiver of coverage election boxes may be deleted.</u></p> <p><u>Cancer Coverage Questions</u></p> <p>(7) <u>This section may be deleted in its entirety based on the type of underwriting method.</u></p> <p>(8) <u>This sentence may be deleted if an Evidence of Insurability form is not required.</u></p> <p>(9) <u>The 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.</u></p> <p>(10) <u>The time frame may vary within the range of 2 to 20 years but will not exceed the time frame allowed by any applicable law.</u></p> <p>(11) <u>This text may be deleted. Conditions may be added, deleted or changed as needed.</u></p>

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<u>QS</u>	<p>Health History</p> <p>(1) This section will appear when Short-Term, Long-Term, Basic Life Insurance, and/or Voluntary Life Insurance, or any combinations of these coverages are being offered. <u>Or, this section may be deleted in its entirety based on the type of underwriting method. And, upon request, this section may appear after the Short-Term, Long-Term, Basic Life Insurance, and/or Voluntary Life Insurance coverage section(s).</u></p> <p>(2) The terminology used to refer to the “Health History” section may change based on planholder request.</p> <p>(3) 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.</p> <p>(4) Text will be changed based on products being offered.</p> <p>(5) Text will be deleted when this form is used for employees only, or when a coverage section is for employees only.</p> <p>(6) The time frame may vary within the range of 3 to 24 months but will not exceed the time frame allowed by any applicable law.</p>
<u>RT</u>	<p>Signature</p> <p>(1) This text will appear when Vision coverage is offered under the plan.</p> <p>(2) This text will appear when dependent Basic or Voluntary Life Coverage is offered under the plan.</p> <p>(3) This text will appear when dependent coverage is offered as part of the plan.</p> <p>(4) This text will only appear when premium amounts are included in the enrollment form.</p> <p>(5) This text will appear based on product/plan specifications.</p> <p><u>(5) This text will only appear when enrolling employer groups.</u></p> <p><u>(6) The text in (6A), (6B), or (6C), or any combination may appear.</u></p> <p>(6)<u>(7)</u> The fraud warnings may be revised to comply with state requirements.</p> <p>(7)<u>(8)</u> The signature may be replaced with an employee/member PIN (personal identification number) or digitized signature, depending on type of enrollment.</p>
<u>SU</u>	<p>Enrollment Kit Number and Benefits Hotline</p> <p>(1) The Enrollment Kit Number may change or may not appear.</p> <p>(2) The benefits hotline name and telephone number may change or may not appear. Additionally, the website address may change <u>or may not appear.</u></p>
<u>FV</u>	<p>Fraud Warning Statements</p> <p>(1) The fraud warning statements page may be revised to comply with state requirements.</p>

CERTIFICATION OF READABILITY

Form number(s): CEF2012

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: 6/27/12