GROUP BENEFITS FROM THE HARTFORD

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

THE HARTFORD

ENROLLMENT FORM

EMPLOYER INFORMATION	EMPLOYER'S FULL LEGAL NAME			GROUP POLICY#
ENROLLMENT INFORMATION	Please check one of the following:			
	☐ INITIAL ENROLLMENT			EFFECTIVE DATE:
	☐ CHANGE TO EXISTING ENROLLMENT			EFFECTIVE DATE:
	☐ FAMILY STATUS CHANGE (TYPE):			EFFECTIVE DATE:
EMPLOYEE INFORMATION	EMPLOYEE NAME	DATE OF BIRTH	EMPLOYEE ID/SSN	DATE OF HIRE
	ADDRESS	CITY	STATE / ZIP CODE	GENDER ☐ M ☐ F
	SPECIALTY/OCCUPATION	EARNINGS (AS DEFINED BY THE POLICY) $ ☐HR ☐ MO ☐YR	# HOURS WORKED PER WEEK	LOCATION
DEPENDENT INFORMATION	SPOUSE'S NAME	GENDER ☐ M ☐ F	DATE OF BIRTH	DATE OF MARRIAGE
	CHILD'S NAME	GENDER ☐ M ☐ F	DATE OF BIRTH	
	CHILD'S NAME	GENDER ☐ M ☐ F	DATE OF BIRTH	
	CHILD'S NAME	GENDER ☐ M ☐ F	DATE OF BIRTH	

APPLICABLE BENEFIT ELECTIONS	Please make your benefit elections by checking the appropriate box. Contact your employer for plan details.			
	SHORT TERM DISABILITY	☐ YES	☐ NO	COST:
	For **DISABILITYFLEX℠** choose:	WEEKLY BENEFIT CHOICE $	BENEFIT DURATION	BENEFIT COMMENCEMENT PERIOD
	LONG TERM DISABILITY	☐ YES	☐ NO	COST:
	CORE CRITICAL ILLNESS	☐ EMPLOYEE $	☐ EMPLOYEE AND CHILD(REN) $	☐ NO
	TOBACCO USER ☐ YES ☐ NO	☐ EMPLOYEE AND SPOUSE $	☐ EMPLOYEE AND FAMILY $	COST:
	VOLUNTARY/BUY-UP CRITICAL ILLNESS	☐ EMPLOYEE $	☐ EMPLOYEE AND CHILD(REN) $	☐ NO
	TOBACCO USER ☐ YES ☐ NO	☐ EMPLOYEE AND SPOUSE $	☐ EMPLOYEE AND FAMILY $	COST:
	BASIC LIFE AND AD&D*			
	EMPLOYEE	☐ YES $	☐ NO	COST:
	SPOUSE	☐ YES $	☐ NO	COST:
	CHILD	☐ YES $	☐ NO	COST:
	*If applicable, the accidental death benefit (AD&D) will equal the face amount of the life insurance elected.			
	SUPPLEMENTAL LIFE AND AD&D*			
	EMPLOYEE	☐ YES $	☐ NO	COST:
	SPOUSE	☐ YES $	☐ NO	COST:
	CHILD	☐ YES $	☐ NO	COST:
	*If applicable, the accidental death benefit (AD&D) will equal the face amount of the life insurance elected.			

Prepare today.
Help protect tomorrow.™

APPLICABLE BENEFIT ELECTIONS CONTINUED					
	SUPPLEMENTAL AD&D				
	EMPLOYEE	☐ YES $		☐ NO	COST:
	SPOUSE	☐ YES $		☐ NO	COST:
	CHILD	☐ YES $		☐ NO	COST:
	ACCIDENT	☐ EMPLOYEE	☐ EMPLOYEE AND CHILD(REN)	☐ NO	
	PLAN OPTION:	☐ EMPLOYEE AND SPOUSE	☐ EMPLOYEE AND FAMILY	COST:	

BENEFICIARY INFORMATION

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you. A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time you die.

PRIMARY BENEFICIARY

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

CONTINGENT BENEFICIARY

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

Consent For Community Property States Only: If you live in a community property state – **Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin** – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. **Disclaimer:** Spousal consent does not apply to ERISA plans. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

BENEFICIARY INFORMATION CONTINUED	This will represent that, as spouse of the employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.	
	SIGNATURE OF EMPLOYEE'S SPOUSE	DATE
CONFIRMATION	I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford. I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy. If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit(s) reduce at a specified age(s) stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition. If I have critical illness insurance coverage with The Hartford, I understand and agree that my critical illness insurance benefit is terminated at a specified age stated in the policy and that a claim for benefits may not be approved for a pre-existing condition. I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force. **Fraud Notice(s)** **For Residents of 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. **For Residents of Louisiana and Maryland:** Any person who knowingly (knowingly or willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly or willfully in Maryland) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **For Residents of New York (Not applicable to Life Insurance):** **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.** **For Residents of Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.	
	SIGNED	DATE