Benefits Enrollment Form

Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Clear Form

THE HARTFORD

Instructions: 1) Please print clearly with blue or black ink and provide complete information. (Missing information causes delays.) **2)** Please review the applicable benefit highlight/summary information for each product prior to electing coverage. You (employee) and your dependent(s) (if applicable) are only eligible for coverage as allowed by the applicable group policy. **3)** For each coverage, please check the appropriate box(es) to elect or decline coverage and enter amounts where necessary. **4)** Please sign and date the form. **5)** Submit the form as instructed by your benefits administrator by the enrollment deadline. (Do not submit or send the form directly to The Hartford.)

EMPLOYEE INFORMATION

Name (FIRST MI LAST)	**Employee ID/Social Security Number**	**Date of Birth** (MM/DD/YYYY)

Gender ☐ M ☐ F	**Married** ☐ Yes ☐ No	**Email Address**

Street Address	**City**	**State**	**Zip Code**

Date of Hire (MM/DD/YYYY)	**Hours Worked/Week**	**Position/Job Title/Physician Specialty**	**Salary/Earnings**

Employer Name	**Group Policy Number**	**Class**	**Location**	**Division/Department**

TOBACCO USE INFORMATION (IF YOU DO NOT COMPLETE THIS SECTION, TOBACCO PREMIUMS WILL APPLY TO APPLICABLE COVERAGE(S))

Have you (employee) used tobacco or nicotine replacement in any form in the past 12 months? ☐ Yes ☐ No

DEPENDENT INFORMATION (ADDITIONAL CHILDREN MAY BE LISTED ON SEPARATE PAPER AND ATTACHED TO/SUBMITTED WITH THIS FORM)

Spouse Name (FIRST MI LAST) ☐ N/A	**Date of Birth**	**Gender** ☐ M ☐ F	**Date Married**

Child Name (FIRST MI LAST)	**Date of Birth**	**Gender**	**Child Name** (FIRST MI LAST)	**Date of Birth**	**Gender**
		☐ M ☐ F			☐ M ☐ F
		☐ M ☐ F			☐ M ☐ F

SHORT TERM DISABILITY INSURANCE

Coverage for Employee Only	**Benefit Amount**	**Pay Period Premium Amount**	**Elect Coverage**	**Decline Coverage**
Employee	$_____	$_____	☐	☐

Additional Information:

- Your benefit amount is based on your earnings; therefore, your benefit and premium amount will change as your earnings change. Your premium amount may be based on your age; therefore, your premium amount may change, as you grow older.

DisabilityFLEX® (VOLUNTARY SHORT TERM DISABILITY INSURANCE)

Benefit Commencement Period/Benefit Duration	**Benefit Amount – Select One Option**	**Pay Period Premium Amount**
Benefits Begin: _____ day Duration: _____ weeks	☐ $_____ each week	$_____
☐ Decline Coverage	N/A	N/A

Additional Information:

- Your premium amount is based on your age; therefore, your premium amount will change as you grow older.

LONG TERM DISABILITY INSURANCE

Coverage for Employee Only	**Benefit Amount**	**Pay Period Premium Amount**	**Elect Coverage**	**Decline Coverage**
Employee	$_____	$_____	☐	☐

Additional Information:

- Your benefit amount is based on your earnings; therefore, your benefit and premium amount will change as your earnings change. Your premium amount may be based on your age; therefore, your premium amount may change, as you grow older.

EMPLOYEE NAME: _____

IMPORTANT CANCER AND SPECIFIED DISEASES INSURANCE ELIGIBILITY INFORMATION

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

- Any resident of CA, GA, or NJ (you or your dependent(s)) that does not have major medical insurance (or an equivalent) is not eligible for and should not enroll for critical illness coverage.
- Any resident of CT, ID, ME, NH or WV (you or your dependent(s)) that participates in any Title XIX program (e.g. Medicaid or any similar name) is not eligible for and should not enroll for critical illness coverage.
- Any resident of NY (you or your dependent(s)) that does not have major medical insurance (or an equivalent) is not eligible for and should not enroll for critical illness or specified disease coverage.
- Any resident of NY (you or your dependent(s)) that has coverage under any other specified disease policy is not eligible for and should not enroll for this specified disease coverage, unless the existing coverage is to be replaced in full by this coverage.
- CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

CANCER AND SPECIFIED DISEASES INSURANCE

Coverage for Employee & Dependent(s)	Coverage Tier – Select One Option	Pay Period Premium Amount
Employee Benefit Amount: $_____	☐ Employee Only	$_____
	☐ Employee & Spouse	$_____
	☐ Employee & Child(ren)	$_____
	☐ Employee & Family	$_____
☐ Decline Coverage	N/A	N/A

Coverage for Employee & Dependent(s)	Coverage Amount – Select One Option	Pay Period Premium Amount
Employee	☐ $_____	$_____
	☐ Decline Coverage	N/A
Spouse	☐ $_____	$_____
	☐ Decline Coverage	N/A
Child(ren)	☐ $_____	$_____
	☐ Decline Coverage	N/A

Additional Information:

- Your premium amount is based on your age; therefore, your premium amount may change as you grow older.
- The benefit amount(s) available under this plan may be subject to a reduction schedule (usually beginning at age 70 or 75).

IMPORTANT ACCIDENT INSURANCE ELIGIBILITY INFORMATION

The following notice(s) apply to all Accident and Voluntary Accident coverage presented on this form:

- ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

ACCIDENT INSURANCE

Coverage for Employee & Dependent(s)	Coverage Tier – Select One Option	Pay Period Premium Amount
Plan _____	☐ Employee Only	$_____
	☐ Employee & Spouse	$_____
	☐ Employee & Child(ren)	$_____
	☐ Employee & Family	$_____
	☐ Decline Coverage	N/A

EMPLOYEE NAME: _____

BASIC TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE				
Coverage for Employee & Dependent(s)	**Benefit Amount**	**Pay Period Premium Amount**	**Elect Coverage**	**Decline Coverage**
Employee	$_____	$_____	☐	☐
Spouse	$_____	$_____	☐	☐
Child(ren)	$_____ for each child	$_____	☐	☐

Additional Information:

- The benefit amount(s) available under this plan may be subject to a reduction schedule (usually beginning at age 65 or 70).

VOLUNTARY TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE				
Coverage for Employee & Dependent(s)	**Benefit Amount**	**Pay Period Premium Amount**	**Elect Coverage**	**Decline Coverage**
Employee ☐ Elect AD&D* ☐ Decline AD&D	$_____	$_____	☐	☐
Spouse ☐ Elect AD&D* ☐ Decline AD&D	$_____	$_____	☐	☐
Child(ren) ☐ Elect AD&D* ☐ Decline AD&D	$_____ for each child	$_____	☐	☐

Additional Information:

- *If AD&D is elected, the AD&D benefit amount is equal to the Life benefit amount
- Your benefit amount may be based on your annual earnings; therefore, your benefit and premium amount may change as your earnings change.
- The premium amount(s) for you and your spouse may be based on age; therefore, the premium amount(s) may change as you grow older.
- The benefit amount(s) available under this plan may be subject to a reduction schedule (usually beginning at age 65 or 70).

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE		
Coverage for Employee & Dependent(s)	**Benefit Amount – Select One Option**	**Pay Period Premium Amount**
Employee	☐ $_____	$_____
	☐ Decline Employee Coverage	N/A
Spouse	☐ $_____	$_____
	☐ Decline Spouse Coverage	N/A
Child(ren)	☐ $_____ for each child	$_____
	☐ Decline Child(ren) Coverage	N/A

Coverage Tier – Select One Option		**Employee Benefit Amount**	**Pay Period Premium Amount**	
			EE Only	**Family**
☐ Employee Only (EE Only)	☐ Employee & Family (Family)	$_____	$_____	$_____
☐ Decline Coverage		N/A	N/A	

Additional Information:

- Your benefit amount is based on your annual earnings; therefore, your benefit and premium amount will change as your earnings change.
- The benefit amount(s) available under this plan may be subject to a reduction schedule (usually beginning at age 65 or 70).

IMPORTANT HOSPITAL INDEMNITY INSURANCE ELIGIBILITY INFORMATION

The following notice(s) apply to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- The policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

EMPLOYEE NAME: _____

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** online or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

HOSPITAL INDEMNITY INSURANCE

Coverage for Employee & Dependent(s)	Coverage Tier – Select One Option	Pay Period Premium Amount
Plan _____	☐ Employee Only	$_____
	☐ Employee & Spouse	$_____
	☐ Employee & Child(ren)	$_____
	☐ Employee & Family	$_____
	☐ Decline Coverage	N/A

BENEFICIARY DESIGNATION (PLEASE ENSURE YOUR BENEFICIARY DESIGNATION IS CLEAR SO THERE IS NO QUESTION OF YOUR INTENT)

This designation is for **all** group insurance coverage issued by The Hartford for which benefits are payable to a beneficiary or survivor (as indicated by each specific policy) in the event of your death, unless otherwise requested by you in writing. This designation may be changed upon written request. **All** information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless percentages are stated below. The **percentages must total 100%** for all Primary Beneficiaries and 100% for all Contingent Beneficiaries. If you need to designate more beneficiaries than space will allow, please include the additional information on a separate paper and attach it to/submit it with this form, clearly stating your name. Please consult your benefits administrator or legal advisor for assistance or additional information.

Certain states are community property states. If you live in one of these states – AK, AZ, CA, ID, LA, NV, NM, TX, WA or WI – and designate someone other than your spouse as your beneficiary, state law may require that your spouse consent to the designation. Puerto Rico and certain tribal jurisdictions may also require spousal consent. Spousal consent may not apply to ERISA plans. Please consult your benefits administrator or legal advisor for additional information.

Primary Beneficiary(ies) (PRIMARY BENEFICIARIES ARE FIRST IN LINE TO RECEIVE BENEFITS IF LIVING AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

Contingent Beneficiary(ies) (CONTINGENT(S) WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS ALIVE AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)				**Phone Number**

CONFIRMATION & SIGNATURE

By signing below:

- I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.
- I understand and agree that: 1) 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; 2) My request for coverage may be denied by The Hartford; 3) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) Only the insurance policy(ies) issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy; 6) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 7) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.
- I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy, and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.
- I have read and understand the "Important Notice – Fraud Warning Statements" that applies to my state of residence.

Employee Signature	**Date of Signature**

END OF FORM – PLEASE REVIEW THE "IMPORTANT NOTICE – FRAUD WARNING STATEMENTS" ON THE FOLLOWING PAGE

EMPLOYEE NAME: _____

Benefits Enrollment Form
Important Notice – Fraud Warning Statements
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)

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Please read the statement that applies to your state of residence prior to signing the enrollment form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly 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 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.

For Residents of California: The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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 Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

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

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For residents of New Mexico and North Carolina: Any person who knowingly presents a false or fraudulent claim for payment of 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.

For residents of New York (not applicable to Life Insurance applications in New York): 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 Ohio: Any person who, with intent to defraud or knowing that he 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.

For residents of Oregon: 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

EMPLOYEE NAME: _____