

# Hartford Life and Accident Insurance Company



## LIFE / DISABILITY ENROLLMENT FORM

Initial     
  Change     
  Termination     
  Reinstatement

### TO BE COMPLETED BY THE EMPLOYEE

|                                      |   |  |                             |
|--------------------------------------|---|--|-----------------------------|
| Name: (Last Name, First Name & M.I.) |   | Birthdate (MM/DD/YYYY)   |                             |
| Social Security Number               | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F | Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced<br><input type="checkbox"/> Separated | Date of Marriage (MM/DD/YY) |

Employee Home Address: (Street, City, State & Zip Code)

|   |   |   |
|---|---|---|
| Dependent Information (Complete only if dependent coverage is available and elected.)<br>(Last Name, First Name & M.I.) | Sex: M/F  | (DEPENDENT LIFE ONLY)<br>Birthdate (MM/DD/YYYY) |
| Spouse (Indicate last name if different from Employee)  | <input type="checkbox"/> M <input type="checkbox"/> F |   |
| Child   | <input type="checkbox"/> M <input type="checkbox"/> F |   |
| Child   | <input type="checkbox"/> M <input type="checkbox"/> F |   |
| Child   | <input type="checkbox"/> M <input type="checkbox"/> F |   |

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. (You will not be covered for coverages not included in your Employer's contract.) To elect coverage check the box marked "Y". To declare coverage check the box marked "N."

|  |  |  |   |   |
|--|--|--|---|---|
| <b>Basic Life</b><br><input type="checkbox"/> Y <input type="checkbox"/> N<br>AMT \$ _____   | <b>Supplemental</b><br><input type="checkbox"/> Y <input type="checkbox"/> N<br><input type="checkbox"/> \$ _____ X Basic Amount Earnings<br><input type="checkbox"/> Other \$ _____ | <b>AD/D</b><br><input type="checkbox"/> Y <input type="checkbox"/> N | <b>Supp. ADD</b><br><input type="checkbox"/> Y <input type="checkbox"/> N | <b>Weekly Disability</b><br><input type="checkbox"/> Y <input type="checkbox"/> N<br><input type="checkbox"/> Flat Amount _____ |
| <b>Dependent Life</b><br>Spouse <input type="checkbox"/> Y <input type="checkbox"/> N Amount \$ _____<br>Child <input type="checkbox"/> Y <input type="checkbox"/> N Amount \$ _____ | <b>LTD</b><br><input type="checkbox"/> Y <input type="checkbox"/> N  | <b>LTD Buy-Up</b><br>Option 1 _____ %<br>Option 2 _____ %            |   |   |

Beneficiary Designation - Please refer to the reverse side of this form for important information regarding beneficiary designation.

| Full Name          | Address | Social Security No. | Relationship | Date of Birth |
|--------------------|---------|---------------------|--------------|---------------|
| <b>PRIMARY:</b>    |         |                     |              |               |
| <b>CONTINGENT:</b> |         |                     |              |               |

I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed, and I authorize my Employer to make the appropriate deductions, if any, from my wages for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between The Hartford and my Group Plan.

I hereby waive the coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to The Hartford, before my coverage will become effective.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### TO BE COMPLETED BY THE EMPLOYER

|                        |                                 |                                  |                                 |                                 |                                    |
|------------------------|---------------------------------|----------------------------------|---------------------------------|---------------------------------|------------------------------------|
| Policy Symbol          | Policy Number                   | Bill Unit                        | Loss Unit:                      | Business Location:              | Original Effective Date of Policy: |
| Employer Name          |                                 |                                  | Employee Hire Date              | Effective Date of Coverage      |                                    |
| Employee Occupation    |                                 |                                  | Employee Class                  | Life                            | WD      LTD                        |
| Salary \$ _____        | <input type="checkbox"/> Annual | <input type="checkbox"/> Monthly | <input type="checkbox"/> Weekly | <input type="checkbox"/> Hourly |                                    |
| Termination Date _____ |                                 |                                  | Reinstatement Date _____        |                                 |                                    |

**For Policyholders covered under Pennsylvania Long Term Disability policies: If, within 90 days immediately prior to becoming covered under the group contract, you or any dependent have received medical care or advice for a disease or physical condition, you, he or she may not be covered for such disease or physical condition until you, he or she has been covered for one year under this contract. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received within 90 days immediately prior to becoming covered under the group contract.**

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## LIFE / DISABILITY ENROLLMENT FORM

Initial     Change     Termination     Reinstatement

### TO BE COMPLETED BY THE EMPLOYEE

|  |  |   |  |
|--|--|---|--|
| Name: Last<br><b>Doe</b>                     | First<br><b>John</b>   | M.I.<br><b>F</b>  | Brthdate (MM/DD/YYYY)<br><b>09/09/1960</b>       |
| Social Security Number<br><b>XXX-XX-XXXX</b> | Sex<br><input checked="" type="checkbox"/> M<br><input type="checkbox"/> F | Marital Status<br><input type="checkbox"/> Single<br><input type="checkbox"/> Widowed<br><input type="checkbox"/> Separated<br><input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Divorced | Date of Marriage (MM/DD/YY)<br><b>02/03/1997</b> |

|  |                         |                    |                          |
|--|-------------------------|--------------------|--------------------------|
| Employee Home Address: Street<br><b>123 Any Lane</b> | City<br><b>Anywhere</b> | State<br><b>CT</b> | Zip Code<br><b>11111</b> |
|--|-------------------------|--------------------|--------------------------|

|  |  |   |
|--|--|---|
| Dependent Information (Complete only if dependent coverage is available and elected.)<br>Last First M.I. | Sex: M/F   | (DEPENDENT LIFE ONLY)<br>Birthdate (MM/DD/YYYY) |
| Spouse (Indicate last name if different from Employee)<br><b>Doe Jane A.</b>                             | <input type="checkbox"/> M <input checked="" type="checkbox"/> F | <b>07/26/196</b>                                |
| Child  | <input type="checkbox"/> M <input type="checkbox"/> F            |   |
| Child  | <input type="checkbox"/> M <input type="checkbox"/> F            |   |
| Child  | <input type="checkbox"/> M <input type="checkbox"/> F            |   |

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. (You will not be covered for coverages not included in your Employer's contract.) To elect coverage check the box marked "Y." To declare coverage check the box marked "N."

|  |  |  |   |   |
|--|--|--|---|---|
| <b>Basic Life</b><br><input checked="" type="checkbox"/> Y <input type="checkbox"/> N<br>AMT <b>\$ 5,000.</b>  | <b>Supplemental</b><br><input type="checkbox"/> Y <input type="checkbox"/> N<br><input type="checkbox"/> _____ X Basic Amount Earnings<br><input type="checkbox"/> Other _____ | <b>AD/D</b><br><input type="checkbox"/> Y <input type="checkbox"/> N | <b>Suppl ADD</b><br><input type="checkbox"/> Y <input type="checkbox"/> N | <b>Weekly Disability</b><br><input type="checkbox"/> Y <input type="checkbox"/> N<br><input type="checkbox"/> Flat Amount |
| <b>Dependent Life</b><br>Spouse <input type="checkbox"/> Y <input type="checkbox"/> N Amount _____<br>Child <input type="checkbox"/> Y <input type="checkbox"/> N Amount _____ | <b>LTD</b><br><input checked="" type="checkbox"/> Y <input type="checkbox"/> N   | <b>LTD Buy-Up</b><br>Option 1 _____ %<br>Option 2 _____ %            |   |   |

|  |   |                     |                |                   |
|--|---|---------------------|----------------|-------------------|
| Beneficiary Designation - Please refer to the reverse side of this form for important information regarding beneficiary designation. |   |                     |                |                   |
| Full Name  | Address                                 | Social Security No. | Relationship   | Date of Birth     |
| <b>PRIMARY: Jane Amy Doe</b>   | <b>123 Any Lane Anywhere, CT 11111</b>  | <b>XXX-XX-XXXX</b>  | <b>Spouse</b>  | <b>07/26/1963</b> |
| <b>CONTINGENT: Mark James Doe</b>  | <b>987 Ever Road Any Town, CT 22222</b> | <b>XXX-XX-XXXX</b>  | <b>Brother</b> | <b>05/19/1964</b> |

I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed, and I authorize my Employer to make the appropriate deductions, if any, from my wages for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between The Hartford and my Group Plan.

I hereby waive the coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to The Hartford, before my coverage will become effective.

Signature John F. Doe Date 05/23/2007

### TO BE COMPLETED BY THE EMPLOYER

|  |                                  |  |                                  |   |  |
|--|----------------------------------|--|----------------------------------|---|--|
| Policy Symbol<br><b>GL-GLT</b>           | Policy Number<br><b>22222222</b> | Bill Unit                                  | Loss Unit                        | Business Location<br><b>CT</b>                  | Original Effective Date of Policy<br><b>01/01/1993</b> |
| Employer Name<br><b>ABC Company</b>      |                                  | Employee Hire Date<br><b>10/16/1994</b>    |                                  | Effective Date of Coverage<br><b>02/01/1998</b> |  |
| Employee Occupation<br><b>Supervisor</b> |                                  | Employee Class                             |                                  | Life<br><b>01</b>                               | WD<br><b>01</b>  |
| Salary \$ <b>43,500</b>                  |                                  | <input checked="" type="checkbox"/> Annual | <input type="checkbox"/> Monthly | <input type="checkbox"/> Weekly                 | <input type="checkbox"/> Hourly                        |
| Termination Date _____                   |                                  |  | Reinstatement Date _____         |   |  |

**For Policyholders covered under Pennsylvania Long Term Disability policies: If, within 90 days immediately prior to becoming covered under the group contract, you or any dependent have received medical care or advice for a disease or physical condition, you, he or she may not be covered for such disease or physical condition until you, he or she has been covered for one year under this contract. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received within 90 days immediately prior to becoming covered under the group contract.**

## NAMING YOUR BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary (ies) please indicate their full name, address, social security number, relationship and, if a minor, the age of that minor. If the beneficiary is not related either by blood or marriage insert the words, "**Not Related.**" If you need assistance, contact your company representative or your own legal counsel.

Following are examples of the most common designations:

Mary J. Doe, Wife (not Mrs. John Doe). Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son.

Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares, if they are both living, otherwise to whichever of them survives me.

Estate of the Insured

If you name more than one beneficiary with equal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "1/3 to Mary Jones, Mother and 2/3 to Edith Jones, Wife."

If you find that more space is needed for naming your beneficiary (ies) than that provided on this form please complete a Beneficiary Designation Form GR-11927.