

THE HARTFORD



LIFE / DISABILITY ENROLLMENT FORM

Initial
 Change
 Termination
 Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

Name: Last		First		M.I.	Birthdate (MM/DD/YYYY)	
Social Security Number			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <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.)						
Last		First		M.I.	Sex: M/F	(DEPENDENT LIFE ONLY) 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."						
Basic Life <input type="checkbox"/> Y <input type="checkbox"/> N AMT \$ _____		Supplemental <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> \$ _____ <input type="checkbox"/> Other \$ _____		AD/D <input type="checkbox"/> Y <input type="checkbox"/> N		Supp. ADD <input type="checkbox"/> Y <input type="checkbox"/> N
						Weekly Disability <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Flat Amount \$ _____
Dependent Life Spouse <input type="checkbox"/> Y <input type="checkbox"/> N Amount \$ _____ Child <input type="checkbox"/> Y <input type="checkbox"/> N Amount \$ _____		LTD <input type="checkbox"/> Y <input type="checkbox"/> N		LTD Buy-Up Option 1 _____ % 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
PRIMARY:						
CONTINGENT:						
<input type="checkbox"/> 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.						
<input type="checkbox"/> 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.

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.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company and Hartford Life Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies is Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and conditions under which the policies may continue in force or be discontinued.