

Clear Form**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 ☐ M ☐ F	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ 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 Name, First Name & M.I.)			Sex: M/F	(DEPENDENT LIFE ONLY) Birthdate (MM/DD/YYYY)	
Spouse (Indicate last name if different from Employee)			☐ M ☐ F		
Child			☐ M ☐ F		
Child			☐ M ☐ F		
Child			☐ M ☐ 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 decline coverage check the box marked "N."					
Basic Life ☒ Y ☐ N AMT \$100,000.00 65+=\$65K 70+=\$50K		Supplemental ☐ Y ☐ N ☐ \$ _____ X Basic Amount Earnings ☐ Other \$ _____		AD/D ☒ Y ☐ N same age reduction	
		Supp. ADD ☒ Y ☐ N \$5,000		Weekly Disability ☐ Y ☐ N ☐ Flat Amount _____	
Dependent Life Spouse ☐ Y ☐ N Amount \$ _____ Child ☐ Y ☐ N Amount \$ _____		LTD ☐ Y ☐ 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
PRIMARY:					
CONTINGENT:					
☒ 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 862846	Bill Unit	Loss Unit:	Business Location:		Original Effective Date of Policy: 10/01/2008	
Employer Name Lawndale Elementary School District				Employee Hire Date		Effective Date of Coverage	
Employee Occupation				Employee Class		Life X	WD X
						LTD X	
Salary \$ _____ ☐ Annual ☐ Monthly ☐ Weekly ☐ 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.

Hartford Life and Accident Insurance Company



LIFE / DISABILITY ENROLLMENT FORM

☒ Initial ☐ Change ☐ Termination ☐ Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

Name: Last Doe		First John		M.I. F.		Birthdate (MM/DD/YYYY) 09/09/1960	
Social Security Number XXX-XX-XXXX		Sex ☒ M ☐ F		Marital Status ☐ Single ☐ Widowed ☐ Separated ☒ Married ☐ Divorced		Date of Marriage (MM/DD/YY) 02/03/1997	
Employee Home Address: Street 123 Any Lane				City Anywhere		State CT	
				Zip Code 11111			
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) Doe Jane A.				☐ M ☒ F		07/26/1936	
Child				☐ M ☐ F			
Child				☐ M ☐ F			
Child				☐ M ☐ 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 decline coverage check the box marked "N."							
Basic Life ☒ Y ☐ N AMT \$5,000.		Supplemental ☐ Y ☐ N ☐ _____ X Basic Amount Earnings ☐ Other _____		AD/D ☐ Y ☐ N		Suppl ADD ☐ Y ☐ N	
Weekly Disability ☐ Y ☐ N ☐ Flat Amount		Dependent Life Spouse ☐ Y ☐ N Amount _____ Child ☐ Y ☐ N Amount _____		LTD ☒ Y ☐ 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	
PRIMARY: Jane Amy Doe		123 Any Lane Anywhere, CT 11111		XXX-XX-XXXX		Spouse	
CONTINGENT: Mark James Doe		987 Ever Road Any Town, CT 22222		XXX-XX-XXXX		Brother	
☒ 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 GL-GLT	Policy Number 22222222	Bill Unit	Loss Unit	Business Location CT		Original Effective Date of Policy 01/01/1993	
Employer Name ABC Company				Employee Hire Date 10/16/1994		Effective Date of Coverage 02/01/1998	
Employee Occupation Supervisor				Employee Class		Life 01	WD 01
Salary \$ 43,500				☒ Annual ☐ Monthly ☐ Weekly ☐ Hourly			
Termination Date _____				Reinstatement Date _____			

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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.