The Hartford Life Insurance Company
c/o MGM Benefits Group - Third Party Administrator
2121 N Glenville Drive
Richardson, TX 75082
Fax: 972.881.2251

Benefit Coverage
☐ Initial Enrollment
☐ New Hire
☐ Annual Enrollmment
☐ Change Request

If Change, type of Change:
☐ Class Change
☐ Name Change
☐ Address Change
☐ Salary Change

Enrollment Form
New Jersey Educator Long-Term Disability

Section 1: Information About You				
Employer's Company Name				Effective Date
Employee Last Name	Employee First Name		MI	Social Security Number
Physical Address				Annual Salary
City		State		Zip Code
Date of Birth	Gender	Date of Hire		Hours Worked Per Week
Occupation			Class (if applicable)	

Section 2: Educator LTD Enrollment						
Plan:	☐ Platinum	☐ Gold	☐ Bronze			
Elimination Period:	☐ 7 Days	☐ 14 Days	☐ 30 Days	☐ 60 Days	☐ 90 Days	☐ 180 Days

Monthly Benefit Amount:	Monthly Premium:	Payroll Deduction Mode:
$	$	☐ 10 Per Year ☐ 12 Per Year ☐ Other: _____

What portion of your monthly premium is employer paid (if any)? _____ % or $ _____

Section 3: Employee Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage described in the Benefit Highlight Sheet and offered through my employer. 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 the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your 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.

I authorize my employer to make the appropriate payroll deductions from my earnings.

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 not met, this policy will not be implemented and the coverage I have elected will not be in force.

Employee Signature:	Date: