Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

THE HARTFORD

ROSEVILLE JOINT UNION HIGH SCHOOL DISTRICT

Roseville Joint Union High School District Benefits Enrollment Form

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter and/or check** your coverage elections. Make sure the coverage amount that you elect includes your existing coverage amount. You may only elect and will be covered for levels of coverage included in your employer's contract.
- **Step 2:** Please **sign, date and return** this form to **The Payroll Department**. Do not mail this form back to The Hartford's address indicated at the top of this form.

Information About You				
Employee Name:		**Employee ID (if not available, then Social Security Number):**		
Address:		**City:**	**State:**	**Zip Code:**
Email Address:			**Date of Birth:**	
Date of Hire:	**Class:**	**Earnings:**	**Number of Hours Worked Per Week:**	
Position:		**Location/Department/Division:** Roseville Joint Union HS District		
Policy Number: 678150				

Dependent Information			**If more than 4 child(ren), attach additional sheet.**		
Spouse Name (includes domestic partner):		**Gender:**	**Spouse Date of Birth:**	**Date of Marriage or Eligible Partnership:**	
		☐ M ☐ F			
Child Name:	**Gender:**	**Date of Birth:**	**Child Name:**	**Gender:**	**Date of Birth:**
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

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Prepare today.
Help protect tomorrow.

Name: _____

Employer Paid Basic Life and AD&D Insurance

You are automatically enrolled in $70,000 of Basic Life & AD&D Insurance which is paid for by your employer.

Basic Dependent Life

You must elect depend basic life insurance. Premium is paid for by your employer. Spouse coverage is $1,000 and child(ren) coverage from live birt to 6 months is $250 and from 6 months to 26 the benefit amount is $1,000.

☐ I have dependents that should be enrolled in the basic dependent life coverage

☐ I do not have any eligible dependents for the basic dependent life coverage

Voluntary Life and AD&D Insurance

Your cost may change when you move into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.098	0.092	0.0970	0.1320	0.1940	0.2990	0.4900	0.7860	1.0420	1.6160	2.7970	4.778

To calculate your pay period(10thly: August- May) cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x $_____ = $_____

Life and AD&D Benefit Amount | Rate | My pay period(10thly: August- May) Cost

☐ I elect to **purchase** $_____ of life and AD&D coverage.

☐ I **decline** to purchase life and AD&D coverage.

Spouse Voluntary Life and AD&D Insurance

Costs are based on the employee's age. Your cost may change when the employee moves into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.098	0.092	0.0970	0.1320	0.1940	0.2990	0.4900	0.7860	1.0420	1.6160	2.7970	4.778

To calculate your pay period(10thly: August- May) cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x $_____ = $_____

Life and AD&D Benefit Amount | Rate | My pay period(10thly: August- May) Cost

☐ I elect to **purchase** $_____ of life and AD&D coverage.

☐ I **decline** to purchase life and AD&D coverage.

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Name: _____

Child(ren) Voluntary Life Insurance

***In order for a child to have coverage the employee needs to be enrolled in voluntary life benefits.

To calculate your pay period cost, please use the following formula(s):

_____	÷ $1,000 =	_____	x	$0.048	x	_____	=	$ _____
Life and AD&D Benefit Amount				Rate		Number of Covered Children		My pay period(10thly: August- May) Cost

☐ I elect to **purchase** $10,000 of child(ren) life coverage
☐ I **decline** to purchase child(ren) life coverage.

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you. A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time you die.

PRIMARY BENEFICIARY

Primary Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:			**Phone Number:**	
Primary Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:			**Phone Number:**	

CONTINGENT BENEFICIARY

Contingent Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:			**Phone Number:**	
Contingent Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:			**Phone Number:**	

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

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Name: _____

Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that 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. I understand my request for coverage may be denied by The Hartford.

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 my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my 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.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit(s) reduce at a specified age(s) stated in the policy.

I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand rates and benefits may be changed by the insurer.

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 required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force.

Fraud Notice(s)
For Residents of Louisiana and Maryland:
Any person who knowingly (knowingly or willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly or willfully in Maryland) 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 Virginia:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed _____ Date _____

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