

LIFE/DISABILITY ENROLLMENT FORM



Initial
 Change
 Termination
 Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

NAME	LAST	FIRST	M.I.	BIRTH DATE	M/D/Y
SOCIAL SECURITY NUMBER		SEX	MARITAL STATUS		DATE OF MARRIAGE
-		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	<input type="checkbox"/> Married <input type="checkbox"/> Divorced	M/D/Y
EMPLOYEE HOME ADDRESS		STREET		CITY	STATE ZIP
DEPENDENT INFORMATION <i>(Complete only if dependent coverage is available and elected.) [DEP LIFE ONLY]</i>					
LAST			FIRST		
M.I.			SEX: M/F	BIRTHDATE: M/D/Y	
SPOUSE <i>(Indicate last name if different than Employee)</i>					
CHILD					
CHILD					
CHILD					

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 <input type="checkbox"/> Y <input type="checkbox"/> N AMT _____	SUPP'L LIFE <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> _____ x Basic Annual Earnings <input type="checkbox"/> OTHER _____	AD/D <input type="checkbox"/> Y <input type="checkbox"/> N	WEEKLY DISABILITY <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> FLAT AMT _____	LTD <input type="checkbox"/> Y <input type="checkbox"/> N
DEPENDENT LIFE SPOUSE <input type="checkbox"/> Y <input type="checkbox"/> N AMT _____ CHILD <input type="checkbox"/> Y <input type="checkbox"/> N AMT _____		SUPP AD/D <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	SSN	RELATIONSHIP	D.O.B.
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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 to pay 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 STATE	ORIGINAL EFFECTIVE DATE OF POLICY
EMPLOYER NAME			EMPLOYEE HIRE DATE		EFFECTIVE DATE OF COVERAGE
EMPLOYER 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.