Clear Form

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	Marital Status	Date Of Marriage (MM/DD/YY)
	☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	

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)	☐ 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 declare coverage check the box marked "N."

Basic Life	Supplemental	AD/D	Supp. ADD	Weekly Disability
☒ Y ☐ N AMT $ 5,000.00	☐ Y ☐ N ☐ $ _____ X Basic Amount Earnings ☐ Other $ _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N ☐ Flat Amount $ _____

Dependent Life	LTD	LTD Buy-Up
Spouse ☐ Y ☐ N Amount $ _____ Child ☐ Y ☐ N Amount $ _____	☐ Y ☐ N	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:					

☐ 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	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 $ _____ ☐ 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 yearunder 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.

THE HARTFORD

LIFE / DISABILITY ENROLLMENT FORM

[X] Initial [ ] Change [ ] Termination [ ] Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

Name: Last	First	M.I.	Birthdate (MM/DD/YYYY)
Doe	*John*	*F.*	*09/09/1960*

Social Security Number	Sex	Marital Status	Date Of Marriage (MM/DD/YY)
XXX-XX-XXXX	[X] M [ ] F	[ ] Single [X] Married [ ] Widowed [ ] Divorced [ ] Separated	**02/03/1997**

Employee Home Address: Street	City	State	Zip Code
123 Any Lane	*Anywhere*	*CT*	*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 [X] F	*07/26/1963*
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 declare coverage check the box marked "N."

Basic Life	Supplemental	AD/D	Suppl ADD	Weekly Disability
[X] Y [ ] N AMT $ 5,000.	[ ] Y [ ] N [ ] _____ X Basic Amount Earnings [ ] Other _____	[ ] Y [ ] N	[ ] Y [ ] N	[ ] Y [ ] N [ ] Flat Amount

Dependent Life	LTD	LTD Buy-Up
Spouse [ ] Y [ ] N Amount _____ Child [ ] Y [ ] N Amount _____	[X] Y [ ] N	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:	*Jane Amy Doe*	*123 Any Lane Anywhere, CT 11111*	*XXX-XX-XXXX*	*Spouse*	*07/26/1963*
CONTINGENT:	*Mark James Doe*	*987 Ever Road Any Town, CT 22222*	*XXX-XX-XXXX*	*Brother*	*05/19/1964*

[X] 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	Policy Number	Bill Unit	Loss Unit	Business Location	Original Effective Date of Policy
GL-GLT	**22222222**			**CT**	**01/01/1993**

Employer Name	Employee Hire Date	Effective Date Of Coverage
ABC Company	**10/16/1994**	**02/01/1998**

Employee Occupation	Employee Class	Life	WD	LTD
Supervisior		**01**		**01**

Salary $ **43,500** [X] 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 yearunder 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.