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	**Supplemental**	**AD/D**	**Supp. ADD**	**Weekly Disability**
☒ Y ☐ N AMT $ 20,000.00	☐ 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:
GRH	693914			Stoneham, MA	11/01/2003

Employer Name	Employee Hire Date	Effective Date of Coverage
SEEM Collaborative		
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 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.

Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
200 Hopmeadow Street
Simsbury, Connecticut 06089
(A stock insurance company)

SEEM COLLABORATIVE

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 Human Resources. 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):**
Date of Birth:	
Date of Hire:	

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

Name: _____

Voluntary Short Term Disability Insurance

If coverage amounts are based on Earnings, your cost may change if your Earnings change. Your cost may also 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	0.2450	0.3050	0.2950	0.2050	0.1600	0.1750	0.1750	0.2150	0.2300	0.2450	0.2450	0.2450

To calculate your Semi-monthly cost, please use the following formula(s):

_____ ÷ 52 = _____ x 60% = _____ ÷ 10 = _____ x _____ = $_____

Your Annual Earnings	Your Weekly Earnings	Weekly Benefit Max = $1,000		Rate	Semi-monthly Cost

☐ I elect to **purchase** short term disability coverage.

☐ I **decline** to purchase short term disability coverage.

Supplemental Life Insurance

If coverage amounts are based on Earnings, your cost may change if your Earnings change. Your cost may also 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	0.0200	0.0200	0.0300	0.0400	0.0600	0.0950	0.1700	0.2600	0.3450	0.5700	0.9750	1.8050

To calculate your Semi-monthly cost, please use the following formula(s):

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

Life Benefit Amount		Rate	Semi-monthly Cost

☐ I elect to **purchase** $_____ of life coverage.

☐ I **decline** to purchase life coverage.

Spouse Supplemental Life 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	0.0200	0.0200	0.0300	0.0400	0.0600	0.0950	0.1700	0.2600	0.3450	0.5700	0.9750	1.8050

To calculate your Semi-monthly cost, please use the following formula(s):

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

Life Benefit Amount		Rate	Semi-monthly Cost

☐ I elect to **purchase** $_____ of life coverage.

☐ I **decline** to purchase life coverage.

Name: _____

Child(ren) Supplemental Life Insurance

To calculate your Semi-monthly cost, please use the following formula(s):

_____	÷ $1,000 =	_____	x	$0.0200	x	_____	= $	_____
Life Benefit Amount				Rate		Number of Covered Children		Semi-monthly Cost

☐ I elect to **purchase** $5,000 $_____ of life coverage.

☐ **I decline** to purchase 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.

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. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

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 and willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly and 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 New York (Not applicable to Life Insurance):
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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_____