THE HARTFORD

LIFE / DISABILITY ENROLLMENT FORM



Initial	☐ Change	Term	ination	Reinst	atement				TFORD	
		٦	TO BE COMPL	ETED B	Y THE EN	IPLOYEE				
Name: Las	Last First					M.I	. Bi	Birthdate (MM/DD/YYYY)		
Social Security Number			ex] M] F	larried ivorced	ried		Date Of Marriage (MM/DD/YY)			
Employee Home A	ddress: Street	I .	l	City	/		Sta	ate	Zip Code	
Dependent Infor	mation (Complete onl	able and ele	ected.)	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				
	overage below. You m s contract.) To elect c								es not included	
Basic Life Y N AMT_\$ Other \$ Supplemental Y N X Basic Amount Earnings					D Y N	Supp. ADD Y N	Week	Iy Disability Y N Flat Amount \$		
Dependen Spouse Child		unt \$	LTD	N	LTD Buy-l Option 1 Option 2	Up 				
Beneficiary Design	nation - Please refer to	the reverse	side of this form for	r important i	nformation re	garding beneficia	ary designa	ation.		
	Full Name	A	ddress			Social Se	curity No.	Relationship	Date of Birth	
PRIMARY:										
CONTINGENT:										
appropriate the provision I hereb	y apply for the coverage deductions, if any, from of the contract being waive the coverages	om my wages ween The H	s for my share of the artford and my Grone. I understand the	ne cost. I ur oup Plan. at if I desire	nderstand that to apply for	at the coverages	available to	o me are in accor	rdance with	
furnish, at my own expense, medical evidence in support of insurability Signature					y, that is satisfactory to The Hartford, before my coverage will become effective					
		Т/	O DE COMDI E	TED BV T	UE EMDI (VED				
Policy Symbol	Policy Number	Bill Unit	D BE COMPLET Loss Unit:	Business		JIEK		Original Eff	ective Date	
T olloy Cyrribol	1 Glioy Prairisei	Diii Oriit	Loos orna.	Buoinicoo	Location.			of Policy:	conve Bate	
Employer Name					Employee Hire Date			Effective Date Of Coverage		
Employee Occupation				Er	Employee Class Life WD LTD			LTD		
Salary \$		Annual	☐ Monthly	☐ We	eekly	Hourly	1			
Termination Date					Reinstat	ement 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	Reinst	atement			HART	FORD		
		TO BE COMPL	ETED B	Y THE EMP	PLOYEE					
Name:	Last Doe	First John		M.I. F.			Birthdate (MM/DD/YYYY) 09/09/1960			
Social Security Number XXX-XX-XXXX		Sex M F	Marital Status M Single			Date	te Of Marriage (MM/DD/YY) 03/1997			
Employee Home A	ddress: Street ny Lane		City An	ywhere		State CT		p Code 1111		
Dependent Infor	mation (Complete only if de	pendent coverage is availa First	able and ele M.I.		Sex: M/F		T LIFE ONLY) MM/DD/YYYY)			
Spouse (Indicate la	ast name if different from En	ployee)								
Doe		Jane	Α.		\square M X F	07/26/	1963			
Child					□м□ғ					
Child					\square M \square F					
Child					□м□ғ					
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 N N N N N N N N N N N N N N N N N										
AMT_ \$5, 0		X Basic Amount Earr	nings			Flat	Amount			
Dependent Life LTD LTD Buy-Up Spouse Y N Amount N Amount Option 1 % Child Y N Amount Option 2 %										
Beneficiary Design	nation - Please refer to the re	everse side of this form for	r important i	nformation rega	arding beneficia	ry designation				
Full Name		Address	Address				lationship	Date of Birth		
PRIMARY: Jane Amy Doe		123 Any Lane	123 Any Lane Anywhere, CT 11111				pouse	07/26/1963		
CONTINGENT:	Mark James Doe	987 Ever Road	Any Tow	ın, CT 2222	22 XXX-XX	K-XXXX E	Brother	05/19/1964		
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										
	ny own expense, medical e	_	ırability, that	is satisfactory	to The Hartford		Ü			
Signature	John F.	Doe				Date	05 23 20			
		TO BE COMPLET	1		YER					
Policy Symbol	Policy Number Bill U	nit Loss Unit	Business L	_ocation			Original Effect of Policy			
GL-GLT	2222222		СТ				, (01/01/1993		
ABC Compa	ny		Employee Hire Date 10/16/1994			Effective Date Of Coverage 02/01/1998				
Employee Occupat Supervisior	ion	Er	nployee Class		Life 01	WD	LTD 01			
<u> </u>	13,500 X Anr	ual Monthly		Veekly	Hourly	I				
Termination Date				Reinstater						

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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.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company and Hartford Life Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies is Simsbury, CT. All benefits are subject to the terms and conditions of the policie. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and conditions under which the policies may continue in force or be discontinued.