# THE HARTFORD



LIFE / DISABILITY ENROLLMENT FORM										THE			
☐ Initial ☐ Change ☐ Termination ☐ Reinstatement									Har	ΓFORD			
TO BE COMPLETED BY THE EMPLOYEE													
Name: Last	Name: Last First					M.I.				Birthdate (MM/DD/YYYY)			
Social Security N	lumber		Sex						Date Of Marriage (MM/DD/YY)				
Employee Home Address: Street						City				ate	Z	Zip Code	
Dependent Information	nd ele	ected.)	ed.) M.I. Sex: M/F Birtl				LIFE ONLY	)					
Spouse (Indicate last name if different from Employee)								] M 🗌 F					
Child								M _ F					
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 declare coverage check the box marked "N."													
Basic Life  Y N  AMT \$ X Basic Amount Earnings  Other \$					AD/			ADD Y N	Week	ekly Disability  Y N  Flat Amount \$			
Dependent Life         LTD         LTD Buy-Up           Spouse         Y N Amount \$ Option 1													
Beneficiary Design	Beneficiary Designation - Please refer to the reverse side of this form for important						tant information regarding beneficiary des     Social Security N						
Full Name PRIMARY:			Address Social						curity INO.	Reia	ationsnip	Date of Birth	
CONTINGENT:													
appropriate the provisio	deductions, if any, from the coverage was the contract being waive the coverages any own expense, median	om my wages to tween The Hai s offered to me	for my share rtford and my e. I understan	of the cos Group Plant	t. I ur an. desire	nderstand that to apply for	at the o	coverages	available t rerages at	to me a late	are in accord	dance with be required to	
Signature									Date	-			
			BE COMP				OYER	}					
Policy Symbol Policy Number Bill Unit Loss Unit: Busi					siness Location:					Original Effective Date of Policy:			
Employer Name						Employee Hire Date				Effective Date Of Coverage			
Employee Occupation					Employee Class				Lif	fe	WD	LTD	
Salary \$		Annual	☐ Monthly	, [	] We	ekly	Пно	ourly					
Termination Date						Reinsta	tement	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	☐ Termi	ination	Reins	statement						ΓFORD	
		1	O BE COMP	LETED E	BY THE E	MPLO	YEE					
Name:	Last <b>Doe</b>		First <b>John</b>	M.I. <b>F.</b>			I	Birthdate (MM/DD/YYYY) <b>09/09/1960</b>				
Social Security Number  XXX-XX-XXXX		Se X	ex M F	Marital Status Single X Ma Widowed Div Separated			С			Date Of Marriage (MM/DD/YY) 12/03/1997		
Employee Home A	nddress: Street		,	Ci <b>A</b>	<sub>ty</sub> nywhere	)		_	ate <b>7</b>		Zip Code <b>1111</b>	
Dependent Information (Complete only if depe			ndent coverage is available and elected.)  First  M.I.				Sex: M/F	(DEPENDENT LIFE ONLY) Birthdate (MM/DD/YYYY)				
Spouse (Indicate	ast name if different from	om Employee	)									
Doe		Jai	ne	A	•		MXF	07/2	26/196	3		
Child							м□ғ					
Child							M□F					
Child							M□F					
	overage below. You m s contract.) To elect c									coverage	s not included	
Basic Life  X Y  AMT \$5	N	lemental	Basic Amount Ea	,	AD/D Y N	Supp	I <b>ADD</b> Y  N		ekly Disa Y t Flat Amo	N		
Depender Spouse Child		ount	LTD	Y N	LTD Buy Option 1 Option 2		<u>%</u> %					
Beneficiary Desig	nation - Please refer to			or important	information r	egardin	<del>-</del>					
	Full Name		Address				Social Sec	curity No.	Relation	nship	Date of Birth	
CONTINGENT:	PRIMARY: Jane Amy Doe		123 Any Lane Anywhere, CT 11111				XXX-XX		Spor		07/26/1963	
CONTINGENT.	Mark James Do	e 98	7 Ever Road	Any To	wn, CT 22	2222	XXX-XX	(-XXXX	Brot	her	05/19/1964	
make the in accorda	by apply for the coverage appropriate deductions not with the provisions by waive the coverages my own expense, med	s, if any, from s of the contr	my wages for my act between The e. I understand the in support of ins	share of the Hartford are the Hartford are the Hartford are the Hartford are the Hartford Har	ne cost. I und nd my Group e to apply for	lerstand Plan.	that the cover	overages erages at	available a later da ny cover	to me are	e be required to become effective.	
			BE COMPLE	TED BY	THE EMPL	OYER	2					
Policy Symbol	Policy Number	Bill Unit	Loss Unit		Location					ginal Effe Policy	ctive Date	
GL-GLT Employer Name	2222222			I .	mployee Hir	e Date			ective Da	te Of Cov	<b>01/01/1993</b> /erage	
ABC Compa					0/16/1994				02/01/1		1.70	
Employee Occupation Supervisior					Employee Class				fe 1	WD	LTD <b>01</b>	
Salary \$	43,500 X	Annual	Monthly		Weekly		Hourly					
Termination Date					Reinsta	atement	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.

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