San Marcos Unified School District

2019 VOLUNTARY LIFE INSURANCE – THE HARTFORD

Administered by the San Diego County Office of Education Fringe Benefits Consortium

Program Basics

In addition to any basic life insurance San Marcos Unified School District may provide, eligible employees can purchase more coverage by enrolling in a voluntary term life insurance program. This voluntary supplemental coverage is portable. If you change jobs or retire, you can port your coverage.

Coverage Available

For you:

Employees can apply for Voluntary Life coverage in $10,000 increments. The amount of coverage you purchase may not exceed five times the amount of your basic annual salary or (up to $500k).

Guaranteed Issue Amount: You are guaranteed $50,000 additional coverage during your original eligibility period (if you enroll within 31 days of your initial eligibility date).

Proof of good health must be provided if coverage is applied for outside of your original eligibility period (first 30 days from your eligibility date.)

Accidental Death and Dismemberment coverage is available in amounts equal to Voluntary Life coverage, up to $250,000

Benefit amounts reduce to 65% of original coverage at age 70 and to 45% of original amount at age 75.

Coverage ends at age 70 for terminated employees who have continued their coverage.

For your spouse:

If your spouse is under age 60, he/she may apply for Voluntary Supplemental Life coverage from $5,000 to $250,000 in $5,000 increments, not to exceed 50% of the employee's coverage.

Accidental Death and Dismemberment coverage is available

Spouse coverage terminates at age 70.

For your children:

Children's Voluntary Life coverage available in amounts of $5,000 or $10,000 if you are covered.

You or your spouse may apply for children's coverage, but not both.

Voluntary Life Insurance Rates:

How to Use the Portable Life Rate Chart to determine your monthly premium:

1. Select the total amount of Voluntary Life coverage you want.
2. Divide by 1,000
3. Multiply the rate shown on the chart for your age.

Rates do not include coverage for Accidental Death and Dismemberment. If you elect this coverage, your rate increases by 0.03 cents per month per $1,000 of coverage, up to the $250,000 limit.

Children's rates are $1.25 per month for $5,000 of coverage and $2.50 per month for $10, 000 of coverage.

Age of Employee/ Spouse	*Rate for Smoker*	*Rate for Non-Smoker*
<25	0.08	0.05
25-29	0.08	0.06
30-34	0.09	0.08
35-39	0.13	0.09
40-44	0.23	0.13
45-49	0.39	0.21
50-54	0.64	0.35
55-59	1.05	0.57
60-64	1.64	0.88
65-69	2.95	1.58
70 and over	5.27	2.81

This is not your Certificate or Schedule of coverage. Certain exclusions and limitations apply. Where/if discrepancies occur the plan Certificate and/or Schedule of coverage will supersede. The Certificate and Schedule of coverage is available on the District website, www.smusd.org.

Group Benefits from The Hartford

Voluntary Life Insurance

Benefit Highlights

San Marcos Unified School District

What is voluntary life insurance?	Voluntary life insurance is coverage that you pay for. Voluntary life insurance pays your beneficiary (please see below) a benefit if you die while you are covered. This highlight sheet is an overview of your voluntary life insurance.
Am I eligible?	You are eligible if you are: • an active full-time employee who works at least 20 hours per week on a regularly • a certificated teacher on a job share plan who works at least 18.75 hours per week on a regularly scheduled basis.
When can I enroll?	You can enroll during your scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of your eligibility waiting period as stated in your group policy.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. You must be actively at work with your employer on the day your coverage takes effect.
How much voluntary life insurance can I purchase?	You can purchase voluntary life insurance in increments of $10,000. The maximum amount you can purchase cannot be more than the lesser of 5 times your annual earnings or $500,000. Annual earnings are as defined in The Hartford's contract with your employer.
Am I guaranteed coverage?	If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of $50,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.
What is a beneficiary?	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.
Are there other limitations to enrollment?	If you do not enroll within 31 days of your first day of eligibility, you will be considered a late entrant. Typically, late entrants may need to show evidence of insurability and may be responsible for the cost of physical exams or other associated costs if they are required.

Spouse Voluntary Life Insurance (includes domestic partner)	If you elect voluntary life insurance for yourself - You may choose to purchase spouse voluntary life insurance in increments of $5,000, to a maximum of $250,000. Spouse voluntary life insurance terminates at age 70. Coverage cannot exceed 50% of the amount of your employee voluntary life insurance coverage. You may not elect coverage for your spouse if they are in active full- time military service or are already covered as an employee under this policy. If your spouse is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of $25,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your spouse's current coverage, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.
Child(ren) Voluntary Life Insurance	If you elect voluntary life insurance for yourself, you may choose to purchase child(ren) voluntary life insurance coverage in the amount(s) listed below – no medical information is required. Coverage cannot exceed 50% of the amount of your employee voluntary life insurance coverage. • Option 1: $5,000 (covers all children) • Option 2: $10,000 (covers all children) • If your dependent child is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. • Child(ren) must be not yet age 26 or meet certain other conditions to be covered. • Unmarried child(ren) over age 26 may be covered if they are disabled and primarily dependent upon the employee for financial support.
Does my coverage reduce as I get older?	Benefits will be reduced by 35% at age 70; and by an additional 55% at age 75. All coverage cancels at retirement.

Can I keep my life coverage if I leave my employer?	Yes, subject to the contract, you have the option of: • Converting your group life coverage to your own individual policy (policies). • If you leave your employer, portability is an option that allows you to continue your life insurance coverage. To be eligible, you must terminate your employment prior to Social Security normal retirement age. This option allows you to continue all or a portion of your life insurance coverage under a separate portability term policy. Portability is subject to a minimum of $5,000 and a maximum of $250,000 and does include coverage for your spouse and child(ren). To elect portability, you must apply and pay the premium within 31 days of the termination of your life insurance. Evidence of insurability will not be required. Dependent spouse portability is subject to a maximum of $50,000. Dependent child(ren) portability is subject to a maximum of $10,000.
What is the living benefits option?	If you are diagnosed as terminally ill with a life expectancy of 12 months or less, you may be eligible to receive payment of a portion of your life insurance. The request cannot exceed 80% of the in force amount of life insurance, and is subject to a minimum of $3,000 and a maximum $240,000. The remaining amount of your life insurance would be paid to your beneficiary when you die.
Do I still pay my life insurance premiums if I become disabled?	If you become totally disabled before age 60 and your disability lasts for at least 9 months, your life insurance premium may be waived. The premium for your dependent's coverage will also be waived if you are disabled and approved for waiver of premium. Coverage for your dependents will end if the policy terminates.

Important Details
As is standard with most term life insurance, this insurance coverage includes certain limitations and exclusions:

- the amount of your coverage may be reduced when you reach certain ages.
- death by suicide (two years).

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

This benefit highlights sheet is an overview of the insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the benefit highlights sheet and the insurance policy, the terms of the insurance policy apply.

Group Benefits from The Hartford

Voluntary Accidental Death & Dismemberment Insurance

Benefit highlights for:

San Marcos Unified School District

What is voluntary accidental death & dismemberment insurance?	Voluntary accidental death & dismemberment insurance pays your beneficiary (please see below) a death benefit if you die due to a covered accident while you are insured. It also pays you a benefit for certain accidental injuries. • Death benefits are paid in addition to any life insurance benefits. • Voluntary accidental death & dismemberment insurance pays benefits for accidental loss of limbs, thumb and index finger, speech, hearing, and sight. • Voluntary accidental death & dismemberment insurance covers losses that occur away from work or at work. Benefits are paid regardless of any workers' compensation benefits you collect. This highlight sheet is an overview of your voluntary accidental death & dismemberment insurance.
What does voluntary accidental death & dismemberment insurance cover?	You may receive benefits due to certain losses or death from an accident. The covered losses or death can occur up to 365 days after that accident. The policy pays for: • 100% of the amount of coverage you purchase in the event of accidental loss of life, or speech and hearing in both ears. • One-half (50%) for accidental loss of one hand or foot, sight of one eye, or speech or hearing in both ears. • One-quarter (25%) for accidental loss of thumb and index finger of the same hand. Additionally, your employer may have elected optional/supplemental benefits as part of your AD&D coverage. Refer to the certificate of insurance for further information. Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage you purchase.
What optional benefits has my employer selected as part of my voluntary accidental death & dismemberment insurance?	• Child Education Benefit • Coma Benefit • Conversion Privilege • Paralysis Benefit • Repatriation Benefit • Seat Belt & Air Bag
Am I eligible?	You are eligible if you are an active full time employee who works at least 20 hours per week or 18.75 hours per week for certificated teachers on job share plan on a regularly scheduled basis.

When can I enroll?	You can enroll during your scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of your eligibility waiting period as stated in your group policy.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. You must be actively at work with your employer on the day your coverage takes effect.
How much voluntary accidental death & dismemberment insurance can I purchase?	You can purchase voluntary accidental death & dismemberment insurance in increments of $10,000. The maximum amount you can purchase cannot be more than 5 times your annual earnings or $250,000. Earnings are as defined in The Hartford's contract with your employer.
Does my coverage reduce as I get older?	Benefits will be reduced to 65% at age 70 and 45% at age 75.
Do I have to provide medical information to receive coverage?	No medical information is required. You are guaranteed the amount of coverage that you select, subject to maximum amounts defined in your policy.
What is a beneficiary?	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding. You are automatically the beneficiary for any dependent coverage and for any AD&D losses other than life.
Voluntary accidental death & dismemberment insurance for your dependents (includes domestic partner)	If you elect voluntary accidental death & dismemberment insurance for yourself, you may also choose voluntary accidental death & dismemberment insurance for your spouse and/or dependent child(ren). You may choose voluntary accidental death & dismemberment insurance for your spouse in increments of $5,000 to a maximum of $250,000. Coverage cannot exceed 50% of the amount of your employee accidental death & dismemberment insurance coverage. You may not elect coverage for your spouse if your spouse is already covered as an employee under this policy. Spouse voluntary accidental death & dismemberment insurance terminates at age 70. You may choose guaranteed voluntary accidental death & dismemberment insurance for each child from live birth but not yet age 26 in the following amounts: • in the amount of $5,000 or $10,000

Important Details
As is standard with most insurance, this voluntary accidental death & dismemberment insurance coverage includes limitations and exclusions. Voluntary accidental death & dismemberment insurance does not cover losses caused by or contributed by:

- sickness; disease; or any treatment for either;
- any infection, except certain ones caused by an accidental cut or wound;
- intentionally self-inflicted injury, suicide or suicide attempt;
- war or act of war, whether declared or not;
- injury sustained while in the armed forces of any country or international authority;
- taking prescription or illegal drugs unless prescribed for or administered by a licensed physician;
- injury sustained while committing or attempting to commit a felony;
- the injured person's intoxication.

Other exclusions may apply depending upon the terms of your policy and other requirements. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

This benefit highlight sheet is an overview of the general purposes of the voluntary accidental death & dismemberment insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the benefit highlight sheet and the policy, the terms of the insurance policy apply.

Group Benefits from The Hartford

Additional Services

Benefit Highlights

San Marcos Unified School District

Does my life insurance coverage include any additional services?

Your life coverage comes with value added services that help with challenges that come before and after a claim.

- **Funeral Planning and Concierge Services**[1] provides a suite of online tools to guide you through key decisions before a loss, including help comparing funeral-related costs. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers—often resulting in significant financial savings.

  For more information on Funeral Planning and Concierge Services
  Call 1-866-854-5429
  Or visit www.everestfuneral.com/hartford Use Code: **HFEVLC**

- **EstateGuidance®[2] Will Services** helps you protect your family's future by creating a will online—backed by online support from licensed attorneys. Your will is customized and legally binding.

  For more information on EstateGuidance® Will Services
  Visit www.estateguidance.com/wills Use Code: **WILLHLF**

- **Beneficiary Assist®[2] Counseling Services** offers compassionate expertise to help you or your beneficiaries (those you name in your policy) cope with emotional, financial and legal issues that arise after a loss. Includes unlimited phone contact with a counselor, attorney or financial planner for up to a year, and five face-to-face sessions.

  For more information on Beneficiary Assist® Counseling Services
  Call 1-800-411-7239

- **Travel Assistance Services with ID Theft Protection and Assistance**[3] includes pre-trip information to help you feel more secure while traveling. It can also help you access medical professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less when unexpected detours arise. The ID theft services are available to you and your family at home or when you travel.

  For more information on Travel Assistance Services or ID Theft Services
  Call 1-800-243-6108
  Collect from other locations: 202-828-5885
  Fax: 202-331-1528
  Or email idtheft@europassistance-usa.com

	Travel Assistance Identification Number: **GLD-09012** You'll be asked to provide your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number, and your company policy number which can be obtained through your Human Resources/Personnel department. If you have a serious medical emergency, please obtain emergency medical services first, and then contact Europ Assistance USA for follow-up.

Important Details

[1] Funeral Planning and Concierge Services are offered through Everest Funeral Package, LLC (Everest). Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affiliates.

[2] EstateGuidance® and Beneficiary Assist® services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. A simple will does not cover credit shelter trust, printing or certain other features. These features are available at an additional cost to you.

[3] Travel Assistance and ID Theft Protection and Assistance are provided by Europ Assistance USA. Europ Assistance is not affiliated with The Hartford and is not a provider of insurance services.

This Benefit Highlights Sheet is an overview of the non-insurance services being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the services as actually provided. Only the Service Provider can fully describe all of the provisions, terms, conditions, limitations and exclusions of your non-insurance service coverage.

Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

THE HARTFORD

San Marcos Unified School District
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**.

Information About You	
Employee Name:	
Social Security Number:	
Date of Birth	Annual Salary:
Date of Hire:	Effective Date:

Dependent Information					If more than 8 children, attach additional sheet.
Spouse Name or Domestic Partner:		Gender:	Spouse or Domestic Partner Date of Birth:	Date of Marriage or Eligible Partnership:	
		M F			
Child Name:	Gender:	Date of Birth:	Child Name:	Gender:	Date of Birth:
	M F			M F	
	M F			M F	
	M F			M F	
	M F			M F	

Prepare today.
Help protect tomorrow.

Name: _____

Employee Voluntary Life Insurance

Costs are based on the employee's age and tobacco user status. Your cost may change when you move into a new age category.

Are you a tobacco user? ☐ Yes ☐ No

Tobacco User

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	$0.0800	$0.0800	$0.0900	$0.1300	$0.2300	$0.3900	$0.6400	$1.0500	$1.6400	$2.9500	$5.2700	$5.2700

Non Tobacco User

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	$0.0500	$0.0600	$0.0800	$0.0900	$0.1300	$0.2100	$0.3500	$0.5700	$0.8800	$1.5800	$2.8100	$2.8100

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

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

Employee Life Benefit Amount | Rate | Monthly Cost

☐ I elect to **purchase** $_____of life coverage.
☐ I **decline** to purchase voluntary employee life coverage.

Spouse Voluntary Life Insurance

Costs are based on your spouse's age. Your cost may change when your spouse 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
Rate	$0.0500	$0.0600	$0.0800	$0.0900	$0.1300	$0.2100	$0.3500	$0.5700	$0.8800	$1.5800

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

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

Spouse Life Benefit Amount | Rate | Monthly Cost

☐ I elect to **purchase** $_____of Spouse life coverage.
☐ I **decline** to purchase spouse life coverage.

Child(ren) Voluntary Life Insurance

☐ I elect to **purchase** $5,000 of Child(ren) life coverage at a monthly cost of $1.25
☐ I elect to **purchase** $10,000 of Child(ren) life coverage at a monthly cost of $2.50
☐ I **decline** to purchase Child(ren) life coverage.

Name: _____

Employee Voluntary Accidental Death & Dismemberment Insurance

If coverage amounts are based on earnings, your cost may change if your earnings change.

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

AD&D Benefit Amount	+ $1,000 =		x	Rate	=	$ Monthly Cost
_____				$0.0300		

☐ I elect to **purchase** $_____of Employee AD&D coverage.
☐ I **decline** to purchase Employee AD&D coverage.

Spouse Voluntary Accidental Death & Dismemberment Insurance

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

AD&D Benefit Amount	+ $1,000 =		x	Rate	=	$ Monthly Cost
_____		_____		$0.0300		

☐ I elect to **purchase** $_____of Spouse AD&D coverage.
☐ I **decline** to purchase Spouse AD&D coverage.

Child(ren) Voluntary Accidental Death & Dismemberment Insurance

☐ I elect to **purchase** $5,000 of Child(ren) AD&D coverage at a monthly cost of $0.15
☐ I elect to **purchase** $10,000 of Child(ren) AD&D coverage at a monthly cost of $0.30
☐ I **decline** to purchase Child(ren) AD&D 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.

Name: _____

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:
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:
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.

Consent For Community Property States Only: If you live in a community property state – **Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin** – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. **Disclaimer:** Spousal consent does not apply to ERISA plans. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will represent that, as spouse of the employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ Date: _____

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 or willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly or 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 _____

Clear Form

Employer Group Benefits Coverage Information

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Please completely fill out **Section 1 and Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1: Employer Details *(to be completed by Employer)*	**PLEASE PRINT CLEARLY**
Employer Name:	Policy Number:
Employer Mailing Address (Street, City, State, Zip Code):	
Division/Location/Subsidiary with Mailing Address *(if applicable):*	
Benefits Contact Name (First, Last):	
Benefits Contact Email Address:	Benefits Contact Phone:

Section 2: Employee Details *(to be completed by Employer)*	**PLEASE PRINT CLEARLY**
Employee Name (First, MI, Last):	Date of Hire (mm/dd/yyyy):
Base Annual Earnings*:	Coverage Effective Date* (mm/dd/yyyy):

* As described in the contract with The Hartford

Life Insurance Coverage Requested

- Enter the dollar amount of **Current Life Coverage, including Guarantee Issue (GI)***. Please include Employee Basic Life coverage even if the employee is not requesting coverage at this time
- Enter the dollar amount of **Life Coverage Subject to Evidence of Insurability (EOI)**

* GI is the maximum amount of coverage as defined in the contract with The Hartford that does not require EOI

	Current Life Coverage, including GI	**Life Coverage Subject to EOI**
Employee Basic Life	$	$
Employee Supplemental or Voluntary Life	$	$
Spouse Basic Life	$	$
Spouse Supplemental or Voluntary Life	$	$

Child Supplemental or Voluntary Life

- Check Yes if employee is requesting Child Life coverage that is subject to EOI ☐ Yes, EOI is required
- Indicate the number of children applying: _____

EVIDENCE OF INSURABILITY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155

Applicant Information

- If there are more than three Applicants, please provide the information on a separate sheet of paper.

Abbreviations: Employee = EE Spouse = SP Child = CH

First Name	Last Name	Social Security Number	EE	SP	CH	Gender (check one)	Height (ft./in.)	Weight (lbs.) If currently pregnant, pre-pregnancy weight	Date of Birth (mm/dd/yyyy)
			☐	☐	☐	☐ Male ☐ Female			
			☐	☐	☐	☐ Male ☐ Female			
			☐	☐	☐	☐ Male ☐ Female			

EE Address: _____ _____	Day Time Phone: _____ Evening Phone: _____ Email Address: _____
SP Address: _____ ☐ same as EE _____	Day Time Phone: _____ Evening Phone: _____ Email Address: _____
CH Address: _____ ☐ same as EE _____	Day Time Phone: _____ Evening Phone: _____ Email Address: _____

Medical Information

Each Applicant must answer each of the following questions to the best of their knowledge and belief. A Legal Guardian is required to answer each of the questions for minor children. If you have more than 1 child, specify which child(ren) the answer applies to on a separate sheet of paper.	**EE**	**SP**	**CH**
Within the past 5 years, have you been diagnosed with or treated by a licensed medical physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you currently pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 consecutive work days due to a disability, injury, or sickness?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 5 years, have you used any controlled substances, with the exception of those taken as prescribed by your physician, been diagnosed or treated for drug or alcohol abuse (excluding support groups), or been convicted of operating a motor vehicle while under the influence of drugs or alcohol?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for:

	EE	**SP**	**CH**		**EE**	**SP**	**CH**
Heart Disease (Do not check "Yes" if you only have High Blood Pressure or a Heart Murmur)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Disease, injury or surgery of Joint, Ligaments, Knee, Back, or Neck (including Arthritis)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Heart-Related Surgery or Heart Attack	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure If you checked "Yes" to High Blood Pressure, have you had a change in medication within the last 6 months?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	Hepatitis (Do not check "Yes" for Hepatitis A) or Cirrhosis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Blocked Arteries (Arteriosclerosis, Atherosclerosis, Aneurysm, or Deep Vein Blood Clot)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Stroke or transient ischemic attack (TIA)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Alzheimer's or Parkinson's Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Paralysis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Major Organ Transplant	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Depression	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Chronic Fatigue Syndrome or Fibromyalgia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sleep Apnea	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Narcolepsy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cancer (Do not check "Yes" for Basal Cell Carcinoma only) If "Yes", Date of Diagnosis: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Ulcerative Colitis or Crohn's Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Psychotic, Psychiatric, Personality, or Bi-Polar Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Kidney Failure or Dialysis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Notice

To the best of your knowledge, you are required to notify Hartford Life and Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date the coverage is approved.

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, copies of medical records which you have authorized us to review, and information obtained from MIB, Inc. Only information that is relevant to determining Evidence of Insurability for the coverage which you are currently requesting will be considered.

Authorization

I, an undersigned applicant, authorize Hartford Life and Accident Insurance Company, together with its affiliates, ("Company") to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

In the event that I cannot be reached via telephone, I authorize a representative of the Company to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that he or she is calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company by telephone.

❒ Yes, you may leave a message as indicated above. ❒ No, please do not leave a message.

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize my employer, any health or benefits plan, physician, medical professional, hospital, clinic, laboratory, MIB Group, Inc. (MIB, Inc), pharmacy or pharmacy benefits manager that possesses my protected personal health information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), to furnish such protected health information to the Company or its representative. The Company may only use information disclosed under this authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

I authorize the Company to disclose the "PHI" in its files to its reinsurer(s) and affiliates, other insurance companies and their affiliates, other persons, representatives and/or organizations performing functions on behalf of the Company and their affiliates, my employer, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me that relates to this application and that such requested information and the identity of the source of the information shall be released to me or, in the case of medical information, to a licensed medical professional of my choice.

I/We authorize Hartford Life and Accident Insurance Company, or its reinsurers, to make a brief report of my/our personal health information to Medical Information Bureau.

I agree that a photocopy of this authorization is valid as the original and I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This authorization shall be valid for twenty-four (24) months from the date signed below. This authorization may be revoked upon written request to the Company, and will not remain valid beyond the date the revocation is received by the Company. I understand the revocation may be a basis for denying my insurance application, and that it does not alter the Company's right to use the application for purposes of determining misrepresentation once coverage has been issued.

I have received and read a copy of the Notice of Insurance Information Practices.

Fraud

For your protection, California law requires the following to appear on this form: The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with the actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Certification

I hereby represent that I have reviewed the above questions and that all statements and answers contained herein are full, complete, and true to the best of my knowledge and belief. For residents of Virginia only: I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

This application will be made a part of the Policy.

Employee Signature	/ / Date Signed	Spouse Signature	/ / Date Signed

Child Signature (Parent/Legal Guardian of the Child is required to sign when submitting dependent Evidence of Insurability on a minor child.)	/ / Date Signed

Please mail the completed **Employer Group Benefits Coverage Information page** and **Evidence of Insurability** application to:

The Hartford

Group Medical Underwriting

P.O. Box 2999

Hartford, CT 06104-2999

If you have any questions or concerns, please call The Hartford Customer Service Department toll-free at 1-800-331-7234, Monday through Friday, 8:00 a.m. to 6:00 p.m., Eastern Time, or email us at medical.uw@thehartford.com.