VOLUNTARY GROUP TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

More than half of Americans (53%) expressed a heightened need for life insurance because of COVID-19.[1]

FLORIDA DEPARTMENT OF REVENUE

The group term Life and Accidental Death and Dismemberment (AD&D) insurance available through your employer is a smart, affordable way to purchase the extra protection that you and your family may need. Life and AD&D insurance offers financial protection by providing you coverage in case of an untimely death or an accident that destroys your income-earning ability. Life benefits are disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life and AD&D insurance, visit **thehartford.com/employee-benefits/employees**

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit[2]: Increments of $10,000 Maximum: the lesser of 5x earnings or $300,000	AD&D: Included
Spouse	Benefit[2]: Increments of $5,000. Maximum: the lesser of 50% of your supplemental coverage or $150,000	AD&D: Not Included
Child(ren)	Benefit: Maximum: $10,000	AD&D: Not Included

AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT	
Covered accidents or death can occur up to 365 days after the accident. The total benefit for all losses due to the same accident will not exceed 100% of your coverage amount.	
LOSS FROM ACCIDENT	**COVERAGE**
Life	100%
Both Hands or Both Feet or Sight of Both Eyes	100%
One Hand and One Foot	100%
Speech and Hearing in Both Ears	100%
Either Hand or Foot and Sight of One Eye	100%
Movement of Both Upper and Lower Limbs (Quadriplegia)	100%
Movement of Both Lower Limbs (Paraplegia)	75%
Movement of Three Limbs (Triplegia)	75%
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	50%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Movement of One Limb (Uniplegia)	25%
Thumb and Index Finger of Either Hand	25%

[2]Your benefit will be reduced by 50% at age 70.

PREMIUMS

See the Life Premium Worksheet.[3]

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 19 (or under age 25 if a full-time student).

AM I GUARANTEED COVERAGE?

If you elect an amount that exceeds the guaranteed issue amount of $80,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

For your spouse coverage, if you elect an amount that exceeds the guaranteed issue amount of $30,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

This insurance is guaranteed issue coverage – it is available without having to provide information about your child(ren)'s health.

AD&D is available without having to provide information about your health.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premiums are provided on the Life Premium Worksheet. You have a choice of coverage amounts. You may elect insurance for you only, or for you and your dependent(s).

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll from 11/1/2023 to 11/30/2023.

WHEN DOES THIS INSURANCE BEGIN?

The effective date of this coverage is 1/1/2024.

You must be actively at work with your employer on the day your coverage takes effect.

Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

WHEN DOES THIS INSURANCE END?

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this life coverage with you. Coverage may be continued for you and your dependent(s) under an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion are described in the certificate. Conversion is not available for AD&D coverage.

[1]LIMRA, Facts About Life 2020: https://www.limra.com/globalassets/limra/newsroom/fact-tank/fact-sheets/liam-facts-2020-final.pdf, as viewed on October 14, 2020.

[3]Rates and/or benefits may be changed on a class basis. Rates are based on the age of the insured person and increase on the policy anniversary date on or following your birthday as you enter each new age category.

The Buck's Got Your Back ®

5962a and 5962b NS 07/21

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your supplemental/voluntary life benefit will be reduced by 50% at age 70.
- A supplemental or voluntary life benefit will not be paid if death occurs by suicide within two years (or as allowed by state law) of purchasing this coverage.
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Coverage may not be elected for a dependent who is in active full-time military service.
- Child(ren) may only be covered as a dependent of one employee.
- Infants may receive a reduced benefit prior to the age of six months.

5962a NS 05/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your supplemental/voluntary AD&D benefit will be reduced by 50% at age 70.
- This insurance does not cover losses caused 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 by or administered by a licensed physician
  - Injury sustained while committing or attempting to commit a felony
  - Injury sustained while driving while intoxicated
- You must be a citizen or legal resident of the United States, its territories and protectorates.

DEFINITIONS

- Loss means, with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to sight, speech or hearing, entire and irrecoverable loss thereof; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints; with regard to movement, complete and irreversible paralysis of such limbs.
- Injury means bodily injury resulting directly from an accident, independent of all other causes, which occurs while you have coverage.

5962c NS 05/21 Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.

The Buck's Got Your Back ®

ADDITIONAL SERVICES

FLORIDA DEPARTMENT OF REVENUE

If you are enrolled in insurance coverage with The Hartford, you may also be eligible to receive additional services. These services help with challenges that come before and after a claim. Be sure to read the information provided below; The Hartford wants to be there when you need us.

SERVICES AVAILABLE

COVERAGE ENROLLED IN	ADDITIONAL SERVICES AVAILABLE
Life	Ability Assist Counseling Services Beneficiary Assist Counseling Services EstateGuidance Will Services Funeral Concierge Services Travel Assistance and ID Theft Protection Services

ASKED & ANSWERED

WHAT IS ABILITY ASSIST COUNSELING SERVICES?

Ability Assist®[1] Counseling Services provides access to Master's degree clinicians for 24/7 assistance if you're enrolled in our life plan. This includes 3 face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

WHAT IS BENEFICIARY ASSIST COUNSELING SERVICES?

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

For more information on Beneficiary Assist® Counseling Services, call 1-800-411-7239.

*California residents are limited to three prepaid behavioral health counseling sessions in any six-month period. Except for acute emergencies and other special circumstances, additional sessions for California employees are available on a fee-for-service basis.

WHAT IS ESTATEGUIDANCE WILL SERVICES?

EstateGuidance®[3] Will Services helps you protect your family's future by creating a customized and legally binding online will. Online support is also available from licensed attorneys, if needed.

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

WHAT IS FUNERAL CONCIERGE SERVICES?

Funeral Concierge Services[4] 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. In addition, Express Pay is a service that delivers proceeds in as little as 48 hours, allowing beneficiaries to use proceeds immediately for funeral expenses.

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

WHAT IS TRAVEL ASSISTANCE AND IDENTITY THEFT SUPPORT SERVICES?

Travel Assistance[6] is available when traveling more than 100 miles from home and for 90 days or less. Services include but are not limited to:

- Medical assistance, including worldwide medical referrals, medical monitoring, prescription transfer, replacement of medical devices and corrective lenses.
- Emergency transports, medical repatriations and evacuations and repatriations of mortal remains.
- Pre-trip information, lost luggage/document assistance and legal referrals.

Identity Theft Support Services[6] provide 24/7/365 assistance including education on how to prevent theft and guidance on what to do if a theft occurs. Caseworkers help review credit information, and if a theft has occurred, will notify major credit bureaus, assist with completing an identity theft affidavit, help with replacing credit/debit cards and more.

For more information on Travel Assistance or Identity Theft Support Services:

- Call from U.S. and Canada: 800-243-6108 (toll-free)
- Call from Outside U.S.: 202-828-5885
- Or email: assist@imglobal.com

In the event of a life-threatening travel emergency, call local emergency authorities first for immediate assistance before contacting our Travel Assistance partner.

[1]AbilityAssist® services are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[2]BeneficiaryAssist® services are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[3]Estate Guidance® services are provided through The Hartford by ComPsych®. A simple will does not cover printing or certain other features. These features are available at an additional cost to you. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Estate Guidance is a registered trademark of ComPsych. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[4]Funeral Concierge services is offered through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. 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. The Hartford is not responsible and assumes no liability for the services provided by Everest Funeral Package, LLC as described in these materials and reserves the right to discontinue any of these services at any time. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[6]Travel Assistance and Identity Theft Support services are offered through a vendor which is not affiliated with The Hartford. These services are not insurance. The Hartford is not responsible and assumes no liability for the goods and services described in these materials and reserves the right to discontinue any of these services at any time. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.

The Buck's Got Your Back ®

5962a NS 05/21

Benefits Enrollment Form

Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Instructions: 1) Please print clearly with blue or black ink and provide complete information. (Missing information causes delays.) **2)** Please review the applicable benefit highlight/summary information for each product prior to electing coverage. You (employee) and your dependent(s) (if applicable) are only eligible for coverage as allowed by the applicable group policy. **3)** For each coverage, please check the appropriate box(es) to elect or decline coverage and enter amounts where necessary. **4)** Please sign and date the form. **5)** Submit the form as instructed by your benefits administrator by the enrollment deadline. (Do not submit or send the form directly to The Hartford.)

EMPLOYEE INFORMATION

Name (FIRST MI LAST)	**Employee ID/Social Security Number**	**Date of Birth** (MM/DD/YYYY)

Gender ☐ M ☐ F	**Married** ☐ Yes ☐ No	**Email Address**

Street Address	**City**	**State**	**Zip Code**

Date of Hire (MM/DD/YYYY)	**Hours Worked/Week**	**Position/Job Title/Physician Specialty**	**Salary/Earnings**

Employer Name	**Group Policy Number**	**Class**	**Location**	**Division/Department**
Dept of Revenue	GL-675266			

TOBACCO USE INFORMATION (IF YOU DO NOT COMPLETE THIS SECTION, TOBACCO PREMIUMS WILL APPLY TO APPLICABLE COVERAGE(S))

Have you (employee) used tobacco or nicotine replacement in any form in the past 12 months? ☐ Yes ☐ No

DEPENDENT INFORMATION (ADDITIONAL CHILDREN MAY BE LISTED ON SEPARATE PAPER AND ATTACHED TO/SUBMITTED WITH THIS FORM)

Spouse Name (FIRST MI LAST) ☐ N/A	**Date of Birth**	**Gender** ☐ M ☐ F	**Date Married**

Child Name (FIRST MI LAST)	**Date of Birth**	**Gender**	**Child Name** (FIRST MI LAST)	**Date of Birth**	**Gender**
		☐ M ☐ F			☐ M ☐ F
		☐ M ☐ F			☐ M ☐ F

SHORT TERM DISABILITY INSURANCE

Coverage for Employee Only	**Benefit Amount**	**Pay Period Premium Amount**	**Elect Coverage**	**Decline Coverage**
Employee	$_____	$_____	☐	☐

Additional Information:

- Your benefit amount is based on your earnings; therefore, your benefit and premium amount will change as your earnings change. Your premium amount may be based on your age; therefore, your premium amount may change, as you grow older.

DisabilityFLEX® (VOLUNTARY SHORT TERM DISABILITY INSURANCE)

Benefit Commencement Period/Benefit Duration	**Benefit Amount – Select One Option**	**Pay Period Premium Amount**
Benefits Begin: _____ day Duration: _____ weeks	☐ $_____ each week	$_____
☐ Decline Coverage	N/A	N/A

Additional Information:

- Your premium amount is based on your age; therefore, your premium amount will change as you grow older.

LONG TERM DISABILITY INSURANCE

Coverage for Employee Only	**Benefit Amount**	**Pay Period Premium Amount**	**Elect Coverage**	**Decline Coverage**
Employee	$_____	$_____	☐	☐

Additional Information:

- Your benefit amount is based on your earnings; therefore, your benefit and premium amount will change as your earnings change. Your premium amount may be based on your age; therefore, your premium amount may change, as you grow older.

EMPLOYEE NAME: _____

IMPORTANT CRITICAL ILLNESS INSURANCE ELIGIBILITY INFORMATION

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

- Any resident of CA, GA, or NJ (you or your dependent(s)) that does not have major medical insurance (or an equivalent) is not eligible for and should not enroll for critical illness coverage.
- Any resident of CT, ID, ME, NH or WV (you or your dependent(s)) that participates in any Title XIX program (e.g. Medicaid or any similar name) is not eligible for and should not enroll for critical illness coverage.
- Any resident of NY (you or your dependent(s)) that does not have major medical insurance (or an equivalent) is not eligible for and should not enroll for critical illness or specified disease coverage.
- Any resident of NY (you or your dependent(s)) that has coverage under any other specified disease policy is not eligible for and should not enroll for this specified disease coverage, unless the existing coverage is to be replaced in full by this coverage.
- **CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

CRITICAL ILLNESS INSURANCE

Coverage for Employee & Dependent(s)	Coverage Tier – Select One Option	Pay Period Premium Amount
Employee Benefit Amount: $_____	☐ Employee Only	$_____
	☐ Employee & Spouse	$_____
	☐ Employee & Child(ren)	$_____
	☐ Employee & Family	$_____
☐ Decline Coverage	N/A	N/A

Additional Information:

- Your premium amount is based on your age; therefore, your premium amount may change as you grow older.
- The benefit amount(s) available under this plan may be subject to a reduction schedule (usually beginning at age 70 or 75).

IMPORTANT ACCIDENT INSURANCE ELIGIBILITY INFORMATION

The following notice(s) apply to all Accident and Voluntary Accident coverage presented on this form:

- **ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

ACCIDENT INSURANCE

Coverage for Employee & Dependent(s)	Coverage Tier – Select One Option	Pay Period Premium Amount
Plan _____	☐ Employee Only	$_____
	☐ Employee & Spouse	$_____
	☐ Employee & Child(ren)	$_____
	☐ Employee & Family	$_____
	☐ Decline Coverage	N/A

BASIC TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Coverage for Employee & Dependent(s)	Benefit Amount	Pay Period Premium Amount	Elect Coverage	Decline Coverage
Employee	$_____	$_____	☐	☐
Spouse	$_____	$_____	☐	☐
Child(ren)	$_____ for each child	$_____	☐	☐

Additional Information:

- The benefit amount(s) available under this plan may be subject to a reduction schedule (usually beginning at age 65 or 70).

EMPLOYEE NAME: _____

VOLUNTARY TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Coverage for Employee & Dependent(s)	Benefit Amount	Pay Period Premium Amount	Elect Coverage	Decline Coverage
Employee ☐ Elect AD&D* ☐ Decline AD&D	$_____	$_____	☐	☐
Spouse ☐ Elect AD&D* ☐ Decline AD&D	$_____	$_____	☐	☐
Child(ren) ☐ Elect AD&D* ☐ Decline AD&D	$_____ for each child	$_____	☐	☐

Additional Information:

- *If AD&D is elected, the AD&D benefit amount is equal to the Life benefit amount
- Your benefit amount may be based on your annual earnings; therefore, your benefit and premium amount may change as your earnings change.
- The premium amount(s) for you and your spouse may be based on age; therefore, the premium amount(s) may change as you grow older.
- The benefit amount(s) available under this plan may be subject to a reduction schedule (usually beginning at age 65 or 70).

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Coverage for Employee & Dependent(s)	Benefit Amount – Select One Option	Pay Period Premium Amount
Employee	☐ $_____	$_____
	☐ Decline Employee Coverage	N/A
Spouse	☐ $_____	$_____
	☐ Decline Spouse Coverage	N/A
Child(ren)	☐ $_____ for each child	$_____
	☐ Decline Child(ren) Coverage	N/A

Coverage Tier – Select One Option		Employee Benefit Amount	Pay Period Premium Amount	
			EE Only	Family
☐ Employee Only (EE Only)	☐ Employee & Family (Family)	$_____	$_____	$_____
☐ Decline Coverage		N/A	N/A	

Additional Information:

- Your benefit amount is based on your annual earnings; therefore, your benefit and premium amount will change as your earnings change.
- The benefit amount(s) available under this plan may be subject to a reduction schedule (usually beginning at age 65 or 70).

IMPORTANT HOSPITAL INDEMNITY INSURANCE ELIGIBILITY INFORMATION

The following notice(s) apply to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

- Any resident of CA, GA, NJ or NY (you or your dependent(s)) that does not have major medical insurance (or an equivalent) is not eligible for and should not enroll for hospital indemnity coverage.
- Any resident of CT, ID, ME, NH or WV (you or your dependent(s)) that participates in any Title XIX program (e.g. Medicaid or any similar name) is not eligible for and should not enroll for hospital indemnity coverage.
- **HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.**
- **HSA COMPATIBILITY.** If you (or any dependent(s)) currently participate in a Health Saving Account (HSA) or if you plan to do so in the future, you should be aware that the IRS limits the types of supplemental insurance you may have in addition to a HSA, while still maintaining the tax-exempt status of the HSA. The IRS allows additional insurance that provides benefits for "a fixed amount per day (or other period) of hospitalization." If you participate in an HSA, you should only enroll for a hospital indemnity (HI) plan that is designated as HSA compatible. In any circumstance, if you participate in an HSA, we encourage you to consult your tax advisor for help with making informed decisions about your supplemental health coverage.

HOSPITAL INDEMNITY INSURANCE

Coverage for Employee & Dependent(s)	Coverage Tier – Select One Option	Pay Period Premium Amount
Plan _____	☐ Employee Only	$_____
	☐ Employee & Spouse	$_____
	☐ Employee & Child(ren)	$_____
	☐ Employee & Family	$_____
	☐ Decline Coverage	N/A

EMPLOYEE NAME: _____

BENEFICIARY DESIGNATION (PLEASE ENSURE YOUR BENEFICIARY DESIGNATION IS CLEAR SO THERE IS NO QUESTION OF YOUR INTENT)

This designation is for **all** group insurance coverage issued by The Hartford for which benefits are payable to a beneficiary or survivor (as indicated by each specific policy) in the event of your death, unless otherwise requested by you in writing. This designation may be changed upon written request. **All** information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless percentages are stated below. The **percentages must total 100%** for all Primary Beneficiaries and 100% for all Contingent Beneficiaries. If you need to designate more beneficiaries than space will allow, please include the additional information on a separate paper and attach it to/submit it with this form, clearly stating your name. Please consult your benefits administrator or legal advisor for assistance or additional information.

Certain states are community property states. If you live in one of these states – AK, AZ, CA, ID, LA, NV, NM, TX, WA or WI – and designate someone other than your spouse as your beneficiary, state law may require that your spouse consent to the designation. Puerto Rico and certain tribal jurisdictions may also require spousal consent. Spousal consent may not apply to ERISA plans. Please consult your benefits administrator or legal advisor for additional information.

Primary Beneficiary(ies) (PRIMARY BENEFICIARIES ARE FIRST IN LINE TO RECEIVE BENEFITS IF LIVING AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

Contingent Beneficiary(ies) (CONTINGENT(S) WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS ALIVE AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

CONFIRMATION & SIGNATURE

By signing below:

- I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.
- I understand and agree that: 1) 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; 2) My request for coverage may be denied by The Hartford; 3) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) Only the insurance policy(ies) issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy; 6) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 7) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.
- I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy, and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.
- I have read and understand the "Important Notice – Fraud Warning Statements" that applies to my state of residence.

Employee Signature	**Date of Signature**

END OF FORM – PLEASE REVIEW THE "IMPORTANT NOTICE – FRAUD WARNING STATEMENTS" ON THE FOLLOWING PAGE

Benefits Enrollment Form
Important Notice – Fraud Warning Statements
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Please read the statement that applies to your state of residence prior to signing the enrollment form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly 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 Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For residents of New Mexico and North Carolina: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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 Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oregon: 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

EMPLOYEE NAME: _____