LIFE/DISABILITY ENROLLMENT FORM

□ Reinstatement

□ Termination

□ Change

Initial

Hartford

CHILD			Т	O BE COMPLE	ETED BY 1	THE EMP	PLOYEE				
Image: Strength of the streng										BIRTH DATE: M/D/Y	
EMPLOYEE HOME ADDRESS STREET CITY STATE ZIP DEFENDENT INFORMATION (Complete out) if dependent coverage is analiable and elecard.) [DEP LIPE ONLY] LAST SEX: MJF BIRTH DATE: M/D/Y SPOUSE (Indicate list name if different has Employee) M.L SEX: MJF BIRTH DATE: M/D/Y CHILD	SOCIAL SECURITY NUM	M □ Single □ □ F □ Married □							DATE OF MARRIAGE: M/D/Y		
LAST First M.L SPOUSE (Indicate last mane if different than Employer) SEX: M/F BIRTH DATE: M/D/Y CRILD	EMPLOYEE HOME ADD	RESS STRE	CET						ZIP		
CHILD	LAST	FIRST	5 1	0	e and elected.) [Ľ	DEP LIFE ONI	-	SEX: M/F	BIR	TH DATE: M/D/Y	
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.) You will not be coverage there will be the box marked "N". BASIC LUE SUPP LIFE ADD SHOR TERM DISABILITY LTD Y N Y N Y N Y N AMT O'THER D'Y N PLAT AMT	CHILD										
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contrace_1 To elect coverage check the box marked "Y.". To decline coverage check the box marked "Y.". Image: Contract of the second page of t	CHILD										
BASIC LIFE SUPP LIFE AD/D SHORT TERM DISABILITY LTD Y N Y N Y N Y N AMT							vill not be co	overed for cov	verages no	t included in your Employer's	
AMT	BASIC LIFE	SIC LIFE SUPP LIFE				SHORT TERM DISABILITY			LTD		
DEPENDENT LIFE SUP AD/D AMOUNT (Choose one) LTD BUY-UP SPOUSE Y N AMT PAD/D AMOUNT (Choose one) UP OPTION 1 % SPOUSE Y N AMT PAD/D PAOUNT (Choose one) OPTION 1 % SPOUSE Y N AMT PAD/DYEE FAMILY OPTION OPTION 1 % GENEFICIARY DESIGNATION Please refer to the second page of this form for important information regarding beneficiary designation. FULL NAME ADDRESS SSN RELATIONSHIP D.O.B. PRIMARY OOTINGENT		•	_ x Basic	c Annual Earnings	ΩΥΩΝ					□ Y □ N	
SPOUSE Y N AMT	DEPENDENT LIFE	□ OTH	ER		SUPP AD/D			(Choose of	ne)	LTD BUY-UP	
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SALARY \$	EMPLOYER NAME EMPLOYEE HIRE DATE			3	EFFECTIV	E DATE OF	COVERAGE	ļ			
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TERMINATION DATE REINSTATEMENT DATE	SALARY \$	🗅 An	nual	□ Monthly	L We	eekly	🗅 Hour	ly			
	TERMINATION DATE				REIN	STATEMEN	T DATE				

For Policyholders covered under Pennsylvania Long Term Disability policies: If, within 90 days immediately prior to becoming covered under the group contract, you or any dependent have received medical care or advice for a disease or physical condition, you, he or she may not be covered for such disease or physical condition until you, he or she has been covered for one year under this contract. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received within 90 days immediately prior to becoming covered under the group contract.

ID-27-4 Send Completed form to: The McKellan Group, Inc. 1449 Old Waterbury Rd Suite #201 Southbury, CT 06488 Fax: 203-575-0308 Phone: 800-531-2001

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 primar *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 or to the survivor.

Estate of the Insured

If you name more than one beneficiary with unequal 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.

LIFE/DISABILITY ENROLLMENT FORM									
	nitial	Change 🗌 Te	ermination	Reinstatemer	nt	Hartford Life			
		TO BE COMPLET	FED BY THE E	MPLOYEE					
NAME LAST Doe SOCIAL SECURITY NUM		FIRST John EX MARITAL STATUS M Single	S.	. I.		BIRTH DATE: M/D/Y 08-10-60 DATE OF MARRIAGE: M/D/Y			
000-00-000		F Married	Separated			06-24-86			
EMPLOYEE HOME ADDRESSSTREET 123 ABC LaneCITYSTATE CITYZIP 00000									
DEPENDENT INFORMAT LAST	TION (Complete only if FIRST	dependent coverage is available of M. I.	and elected.) [DEP LIFE	SEX:	M/F I	BIRTH DATE: M/D/Y			
SPOUSE (Indicate last name if Doe	different than Employed			BEX.		06-04-63			
CHILD	Jane	А.							
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 decline coverage check the box marked "N".									
$\begin{array}{c c} \textbf{BASIC LIFE} \\ \hline{\square} & \textbf{Y} \\ \hline{\square} & \textbf{N} \end{array}$	SUPP LI	IFE		VEEKLY DISABILITY		LTD			
амт \$50,000		x Basic Annual Earnings		FLAT AMT		⊠ Y 🗌 N			
DEPENDENT LIFE SPOUSE CHILD	SUPP AD/D			LTD BUY-UP OPTION 1% OPTION 2%					
		refer to the reverse side of this	-						
FULL NAMEADDRESSPRIMARYJane Amy Doe123 ABC La., Anywhere, CT 000			SSN 20000 121-12-	RELATIO		D.O.B. 06-04-63			
PRIMARY Jane An	ly Doe 125 Al	be La., Anywhere, er e	121-12-	-1212 Spe	ouse	00-04-03			
CONTINGENTMark James Doe6 XYZ St., Anywhere, CT 00000999-99-9999Brother05-19-64									
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 to pay for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between Hartford Life and my Group Plan.									
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Signature	JC	ohn Doe	Date	2/1/98					
-									
POLICY	POLICY	TO BE COMPLE BILL	LOSS	BUSINESS LOCA	TION STATE	ORIGINAL EFFECTIVE			
SYMBOL GL-GLT	NUMBER 2222	UNIT	UNIT	C	Г	DATE OF POLICY 01-01-93			
EMPLOYER NAME		EMPLOYEE HIRE DATE	EFFEC	CTIVE DATE OF COVER	RAGE	01 01 70			
ABC Company EMPLOYEE OCCUPATION		10-16-94 EMPLOYEE CLASS	LIFE	02-01-98 LIFE WD LTD					
Supervisor			01		01				
salary \$ <u>43,500</u>	🛛 Ann	uual 🗌 Monthly	U Weekly	Hourly					
TERMINATION DATE			REINSTATE	MENT DATE					
For Dellardell	D		00 I · I · I						

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