Clear Form

LIFE/DISABILITY ENROLLMENT FORM

☐ Initial ☐ Change ☐ Termination ☐ Reinstatement

Hartford Life

TO BE COMPLETED BY THE EMPLOYEE

NAME LAST	FIRST	M. I.	BIRTH DATE: M/D/Y

SOCIAL SECURITY NUMBER	SEX	MARITAL STATUS	DATE OF MARRIAGE: M/D/Y
	☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	

EMPLOYEE HOME ADDRESS STREET CITY STATE ZIP

DEPENDENT INFORMATION (*Complete only if dependent coverage is available and elected.*) [DEP LIFE ONLY] LAST FIRST M. I.	SEX: M/F	BIRTH DATE: M/D/Y
SPOUSE (***Indicate last name if different than Employee***)		
CHILD		
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".

BASIC LIFE	SUPP LIFE	AD/D	SHORT TERM DISABILITY	LTD
☐ Y ☐ N AMT _____	☐ Y ☐ N ☐ _____ x Basic Annual Earnings ☐ OTHER	☐ Y ☐ N	☐ Y ☐ N ☐ FLAT AMT_____	☐ Y ☐ N

DEPENDENT LIFE			SUPP AD/D	AMOUNT	(Choose one)	LTD BUY-UP
SPOUSE	☐ Y	☐ N AMT _____	☐ Y ☐ N	_____	☐ EMPLOYEE ONLY	OPTION 1 _____%
CHILD	☐ Y	☐ N AMT _____			☐ FAMILY OPTION	OPTION 2 _____%

BENEFICIARY 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					
CONTINGENT					

☐ 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.

☐ I hereby waive the coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to Hartford Life, before my coverage will become effective.

Signature _____ **Date** _____

TO BE COMPLETED BY THE EMPLOYER

POLICY SYMBOL	POLICY NUMBER	BILL UNIT	LOSS UNIT	BUSINESS LOCATION STATE	ORIGINAL EFFECTIVE DATE OF POLICY

EMPLOYER NAME	EMPLOYEE HIRE DATE	EFFECTIVE DATE OF COVERAGE

EMPLOYEE OCCUPATION	EMPLOYEE CLASS	LIFE	STD	LTD

SALARY $ _____ ☐ Annual ☐ Monthly ☐ Weekly ☐ Hourly

TERMINATION DATE	REINSTATEMENT 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

☒ Initial ☐ Change ☐ Termination ☐ Reinstatement

Hartford Life

TO BE COMPLETED BY THE EMPLOYEE

NAME	LAST	FIRST	M. I.	BIRTH DATE: M/D/Y
	Doe	*John*	*S.*	*08-10-60*

SOCIAL SECURITY NUMBER	SEX	MARITAL STATUS		DATE OF MARRIAGE: M/D/Y
000-00-000	☒ M ☐ F	☐ Single ☒ Married	☐ Widowed ☐ Separated ☐ Divorced	*06-24-86*

EMPLOYEE HOME ADDRESS	STREET	CITY	STATE	ZIP
	123 ABC Lane	*Anywhere*	*CT*	*00000*

DEPENDENT INFORMATION (*Complete only if dependent coverage is available and elected.*) [DEP LIFE ONLY]	LAST	FIRST	M. I.	SEX: M/F	BIRTH DATE: M/D/Y
SPOUSE (***Indicate last name if different than Employee***)	*Doe*	*Jane*	*A.*	*F*	*06-04-63*
CHILD					
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".

BASIC LIFE	SUPP LIFE	AD/D	WEEKLY DISABILITY	LTD
☒ Y ☐ N AMT *$50,000*	☐ Y ☐ N ☐ _____ x Basic Annual Earnings ☐ OTHER	☐ Y ☐ N	☐ Y ☐ N ☐ FLAT AMT_____	☒ Y ☐ N

DEPENDENT LIFE				SUPP AD/D	LTD BUY-UP
SPOUSE	☒ Y	☐ N	AMT *$5,000*	☐ Y ☐ N	OPTION 1 _____%
CHILD	☐ Y	☐ N	AMT _____		OPTION 2 _____%

BENEFICIARY DESIGNATION—Please refer to the reverse side of this form for important information regarding beneficiary designation.

	FULL NAME	ADDRESS	SSN	RELATIONSHIP	D.O.B.
PRIMARY	*Jane Amy Doe*	*123 ABC La., Anywhere, CT 00000*	*121-12-1212*	*Spouse*	*06-04-63*
CONTINGENT	*Mark James Doe*	*6 XYZ St., Anywhere, CT 00000*	*999-99-9999*	*Brother*	*05-19-64*

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☐ I hereby waive the coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to Hartford Life, before my coverage will become effective.

Signature **John Doe** **Date** **2/1/98**

TO BE COMPLETED BY THE EMPLOYER

POLICY SYMBOL	POLICY NUMBER	BILL UNIT	LOSS UNIT	BUSINESS LOCATION STATE	ORIGINAL EFFECTIVE DATE OF POLICY
GL-GLT	*22222*			*CT*	*01-01-93*

EMPLOYER NAME	EMPLOYEE HIRE DATE	EFFECTIVE DATE OF COVERAGE
ABC Company	*10-16-94*	*02-01-98*

EMPLOYEE OCCUPATION	EMPLOYEE CLASS	LIFE	WD	LTD
Supervisor		*01*		*01*

SALARY $ *43,500* ☒ Annual ☐ Monthly ☐ Weekly ☐ Hourly

TERMINATION DATE	REINSTATEMENT DATE

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