LIFE/DISABILITY ENROLLMENT FORM

0	Initial	□ Cł	nange 🗅 T	ermination		Reinstatemer	nt	Hartford Life			
			TO BE COMPLI	ETED BY T	THE EMP	LOYEE					
NAME LAST			FIRST		M. I.		BIRTH	DATE: M/D/Y			
GO CILL GEGLIDIEN NUN	TDED.	CENT	A CARTES A CONTRACTOR	TG			D.A. INDE	OF MARRIAGE AND W			
SOCIAL SECURITY NUM	IBEK	SEX	MARITAL STATU				DATE	OF MARRIAGE: M/D/Y			
		□M □F	☐ Single	□ Wido							
		□ F	☐ Married	☐ Separ ☐ Divor							
EMPLOYEE HOME ADD	RESS S	TREET	STATE	ATE ZIP							
DEPENDENT INFORMAT	TON (Complete	e only if dene	ndent coverage is availabl	le and elected) [[OFP LIFE ONI	Y1					
LAST SPOUSE (Indicate last name if	FIRST		SEX: M/F BIRTH DATE: M/D/Y								
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		PP LIFE		AD/D	SHORT T	TERM DISABILI	ITY	LTD			
□ Y □ N	<u> </u>			□ Y □ N							
AMT x Basic Annual Earnings				□ Y □ N □ FLAT AMT			_	□ Y □ N			
DEPENDENT LIFE SPOUSE □ Y □ N AMT CHILD □ Y □ N AMT				SUPP AD/D	AMOUN	EM	Choose one) IPLOYEE ONLY MILY OPTION	TEE ONLY OPTION 1%			
				nis form for imp	ortant informa			tion.			
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.											
St				n	-4-						
Signature					ate						
			TO BE COMPL								
POLICY	POLICY		BILL	LOSS UNIT		BUSINESS LO	CATION STAT				
SYMBOL	NUMBER		UNIT	UNII				DATE OF POLICY			
EMPLOYER NAME		EM	IPLOYEE HIRE DATE	E	EFFECTIVI	E DATE OF COV	ERAGE	l			
EMPLOYEE OCCUPATION		EM	IPLOYEE CLASS		LIFE		TD	LTD			
SALARY \$		Annual	☐ Monthly	□ We	eeklv	☐ Hourly					

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.

REINSTATEMENT DATE

TERMINATION DATE

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

	ial 🗌 Chang	ge	nination	☐ Re	einstatement		Hartford Life				
TO BE COMPLETED BY THE EMPLOYEE											
NAME LAST Doe SOCIAL SECURITY NUMBER	R SEX M	FIRST John ARITAL STATUS		M. I. S.	1	C	TE: M/D/Y 08-10-60 MARRIAGE: M/D/Y				
000-00-000	⊠ M □ □ F ⊠	Single Married	☐ Widowed ☐ Separated ☐ Diversed			06-24-86					
EMPLOYEE HOME ADDRESS STREET CITY STATE ZIP 123 ABC Lane Anywhere CT 00000											
DEPENDENT INFORMATION LAST SPOUSE (Indicate last name if diffe Doe CHILD	FIRST M	coverage is available and I. I.	d elected.) [DEP LIFE ONLY] SEX: M			/F BIRTH DATE: M/D/Y 06-04-63					
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 Y N	Y N N N N X Basic Annual Earnings			AD/D WEEKLY DISABILITY □ Y □ N □ FLAT AMT			LTD ⊠ Y □ N				
AMT \$50,000 DEPENDENT LIFE SPOUSE X Y CHILD Y	SUPP AD/D Y N	☐ FLATA	XWI I		LTD BUY-UP OPTION 1% OPTION 2%						
BENEFICIARY DESIGNA	TION—Please refer to the	e reverse side of this form	_		egarding beneficiary of	designation.					
FULL NAM PRIMARY Jane Amy L	SSN RELATIO 000 121-12-1212 Spo										
CONTINGENT Mark James	s Doe 6 XYZ St., An	ywhere, CT 00000	999-9	9-9999	Brother		05-19-64				
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.											
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 Do	oe .	Date	2/	1/98						
TO BE COMPLETED BY THE EMPLOYER											
	DLICY JMBER 22222	BILL UNIT	LOSS UNIT		SINESS LOCATION CT	N STATE	ORIGINAL EFFECTIVE DATE OF POLICY 01-01-93				
EMPLOYER NAME ABC Com		YEE HIRE DATE 10-16-94	EFFI	ECTIVE DAT	ΓΕ OF COVERAGE	01-98					
EMPLOYEE OCCUPATION Supervisor	1 1	YEE CLASS	LIF 01	E	WD	LTD 01					
SALARY \$ <u>43,500</u>	☐ Annual	☐ Monthly	☐ Weekly] Hourly	<i>01</i>					

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REINSTATEMENT DATE

TERMINATION DATE