Group Benefits from The Hartford

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

Charles County Education Association

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 Employee Plans Service. Do not mail this form back to The Hartford's address indicated at the top of this form.

Information About You			
Employee Name:	**Employee ID (if not available, then Social Security Number):**		
Address:	**City:**	**State:**	**Zip Code:**
Date of Birth:			
Date of Hire:	**Earnings:**	**Number of Hours Worked Per Week:**	
Location/Department/Division:			

Name: _____

Dependent Information					If more than 4 child(ren), attach additional sheet.
Spouse Name:		Gender:	Spouse Date of Birth:	Date of Marriage:	
		☐ M ☐ F			
Child Name:	Gender:	Date of Birth:	Child Name:	Gender:	Date of Birth:
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

DisabilityFLEX Coverage℠

Your cost may change when you move into a new age category.

Semi-monthly rates per $100 weekly benefit:				
Benefit commencement period:	Under age 35:	Age 35-49:	Age 50-59:	Age 60+
13 week benefit duration:				
8th day	$2.2905	$1.5415	$1.7745	$2.1520
30th day	$1.5690	$0.8160	$0.8310	$1.0060
26 week benefit duration:				
8th day	$3.0255	$2.0860	$2.4255	$2.9400
30th day	$2.1600	$1.1435	$1.1745	$1.4225

If the amount of your annual earnings is:	Your election cannot exceed the maximum weekly benefit amount of:
$17,333.33 — $25,999.99	$200
$26,000.00 — $34,666.66	Up to $300
$34,666.67 — $43,333.32	Up to $400
$43,333.33 — $51,999.99	Up to $500
$52,000.00 — $60,666.66	Up to $600
$60,666.67 — $69,333.32	Up to $700
$69,333.33 — $77,999.99	Up to $800
$78,000.00 — $86,666.66	Up to $900
More than $86,666.67	Up to $1000

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

_____ ÷ 100 = _____ x _____ = _____

Elected Weekly Benefit — Rate — Semi-monthly Cost

Name: _____

☐ I elect to **purchase** the _____ day benefit commencement period with the _____ week benefit duration and a $_____ weekly benefit of DisabilityFLEX coverage.
☐ I **decline** to purchase DisabilityFLEX coverage.

Voluntary Long Term Disability Insurance

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

Option 1:

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	0.0995	0.0995	0.3260	0.3260	0.5340	0.5340	0.7615	0.7615	0.5150	0.5150	0.5150	0.5150

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

_____ ÷ 12 = _____ ÷ 100 = _____ x _____ = $_____

Your Annual Earnings Maximum = $71,996.40 | Your Monthly Earnings | Rate | Semi-monthly Cost

Option 2:

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	0.0350	0.3500	0.1110	0.1110	0.1805	0.1805	0.3295	0.3295	0.4220	0.4220	0.4220	0.4220

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

_____ ÷ 12 = _____ ÷ 100 = _____ x _____ = $_____

Your Annual Earnings Maximum = $71,996.40 | Your Monthly Earnings | Rate | Semi-monthly Cost

☐ I elect to **purchase** option 1 long term disability coverage.
☐ I elect to **purchase** option 2 long term disability coverage.
☐ I **decline** to purchase long term disability coverage.

Supplemental Life Insurance

Your cost may change when you move 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	70-74	75+
Rate	0.0595	0.0595	0.0840	0.0840	0.2005	0.2005	0.4925	0.4925	1.0315	1.0315	4.5490	4.5490

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

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

Life Benefit Amount | Rate | Semi-monthly Cost

☐ I elect to **purchase** $_____ of life coverage.
☐ I **decline** to purchase life coverage.

Spouse Supplemental Life Insurance

Costs are based on the employee's age. Your cost may change when the employee moves into a new age category.

Name: _____

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	0.0595	0.0595	0.0840	0.0840	0.2005	0.2005	0.4925	0.4925	1.0315	1.0315	4.5490	4.5490

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

_____ ÷ $1,000 = _____ x _____ = $_____
Life Benefit Amount | Rate | Semi-monthly Cost

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

Child(ren) Supplemental Life Insurance

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

_____ ÷ $1,000 = _____ x $0.0875 x _____ = $_____
Life Benefit Amount | Rate | Number of Covered Children | Semi-monthly Cost

☐ I elect to **purchase** $_____ of life coverage.
☐ I **decline** to purchase life coverage.

Family Voluntary Accidental Death & Dismemberment Insurance

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

Family Member(s) Covered:	Employee Only	Employee & spouse only	Employee & children only	Employee, spouse & child(ren)
Percent of Benefit Paid:	100%	100% for employee 50% for spouse	100% for employee 15% for each child	100% for employee 40% for spouse 10% for each child

Coverage Option:	**Rate:**
Myself only:	$0.0180
Myself and my family:	$0.0295

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

_____ ÷ $1,000 = _____ x _____ = $_____
Elected Benefit Amount (Employee Coverage Amount Only) | Rate | Semi-monthly Cost

☐ I elect to **purchase** $_____ of AD&D coverage for myself only.
☐ I elect to **purchase** $_____ of AD&D coverage for myself. My family will be covered at the percentages of my election listed above.
☐ I **decline** to purchase AD&D coverage.

Name: _____

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.

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:**

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:**

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 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 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_____