

**LIFE/DISABILITY ENROLLMENT FORM**



Initial     Change     Termination     Reinstatement

**TO BE COMPLETED BY THE EMPLOYEE**

NAME LAST		FIRST		M. I.	BIRTH DATE: M/D/Y
SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married		<input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	DATE OF MARRIAGE: M/D/Y
EMPLOYEE HOME ADDRESS	STREET	CITY	STATE	ZIP	

<b>DEPENDENT INFORMATION</b> (Complete only if dependent coverage is available and elected.) [DEP LIFE ONLY]			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".

<b>BASIC LIFE</b> <input type="checkbox"/> Y <input type="checkbox"/> N AMT _____	<b>SUPP LIFE</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> _____ x Basic Annual Earnings <input type="checkbox"/> OTHER	<b>AD/D</b> <input type="checkbox"/> Y <input type="checkbox"/> N	<b>WEEKLY DISABILITY</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> FLAT AMT _____	<b>LTD</b> <input type="checkbox"/> Y <input type="checkbox"/> N
<b>DEPENDENT LIFE</b> SPOUSE <input type="checkbox"/> Y <input type="checkbox"/> N    AMT _____ CHILD <input type="checkbox"/> Y <input type="checkbox"/> N    AMT _____	<b>SUPP AD/D</b> <input type="checkbox"/> Y <input type="checkbox"/> N	<b>LTD BUY-UP</b> OPTION 1 _____ % 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.
<b>PRIMARY</b>				
<b>CONTINGENT</b>				

- 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	WD	LTD
SALARY \$ _____		<input type="checkbox"/> Annual	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> 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.*