

INSTRUCTIONS

Life/Disability Enrollment Form (ID-27)

Employee Instructions

- Have the employee thoroughly complete the top portion of the Enrollment form.
- Employees only need to check the "Y" or "N" boxes for coverages that are included in your policy and for which they are eligible. For example, if your policy with Hartford Life does **not** include Supplemental Life Insurance, neither "Y" or "N" needs to be checked under the SUPP'L LIFE category.
- The employee should only list dependents if dependent coverage is available under the group plan and if the employee is electing to cover them. If a husband and wife work for the same company, only one of them may elect the Dependent Life option, if available.
- If an employee is waiving **all** coverages, only the "I hereby waive coverage..." box needs to be checked. If an employee opts for any of the coverages in the plan, then "I hereby apply for..." box should be checked and the elected coverages must also be indicated.
- If Life coverage is elected, the employee must designate a beneficiary. Information on beneficiary designations is included on the back of the enrollment form and in the Recordkeeping section of this kit.
- Make sure that the employee signs and dates the enrollment form.

Administrator Instructions

- At the top of the enrollment form, make sure to check whether this is an **Initial** enrollment, a **Change**, a **Termination** or a **Reinstatement**.
- You should then complete the shaded portion at the bottom of the form:
 - * The **Policy Number** is a five or six digit number that follows your policy symbol. This number can be found on your premium statement.
 - * The **Bill Unit** and **Loss Unit** do not need to be filled in.
 - * **Business Location:** The state in which the employee is employed.

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	MARITAL STATUS		DATE OF MARRIAGE: M/D/Y
- - -	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
EMPLOYEE HOME ADDRESS	STREET	CITY	STATE	ZIP

DEPENDENT INFORMATION <i>(Complete only if dependent coverage is available and elected.) [DEP LIFE ONLY]</i> LAST FIRST M. I. SEX: M/F BIRTH DATE: M/D/Y SPOUSE <i>(Indicate last name if different than Employee)</i>		
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 <input type="checkbox"/> Y <input type="checkbox"/> N AMT _____	SUPP LIFE <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> _____ x Basic Annual Earnings <input type="checkbox"/> OTHER	AD/D <input type="checkbox"/> Y <input type="checkbox"/> N	WEEKLY DISABILITY <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> FLAT AMT _____	LTD <input type="checkbox"/> Y <input type="checkbox"/> N
DEPENDENT LIFE SPOUSE <input type="checkbox"/> Y <input type="checkbox"/> N AMT _____ CHILD <input type="checkbox"/> Y <input type="checkbox"/> N AMT _____			SUPP AD/D <input type="checkbox"/> Y <input type="checkbox"/> N	LTD BUY-UP 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.
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	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..

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 primary *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.

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- * **Original Effective Date of Policy** - The date that your company's coverage with The Hartford first became effective.
- * **Employer Name** - If Insurance Plan covers multiple entities, always use the name of the entity to which the insurance contract was issued.
- * **Employee Hire Date** - For new employees use the employees date of hire. For current employees who move into an eligible class, be sure to use the date on which the employee became eligible - not the employee hire date.
- * **Effective Date of Coverage** - Date that the employee's coverage becomes effective under the group plan. For new employees, this is the day after the new employee completes the designated Eligibility Waiting Period. For late enrollees, or enrollees requesting benefit amounts in excess of Guaranteed Issue limits, a Personal Health statement must be completed. Coverage will subsequently be effective on the date the individual is approved by the Medical Underwriting Department.
- * **Employee Occupation** - Name of the employee's position or description of type of work done.
- * **Employee Class** - Must be filled in if your insurance plan includes more than one class.
- * **Salary** - The amount the employee earns. Be sure to indicate if the salary is **Annual, Monthly, Weekly** or **Hourly**.
- * **Termination Date** - The date the employee's group coverage ends if the employee is terminating.
- * **Reinstatement Date** - If the enrollment form is being completed because the employee's coverage is being reinstated, please be sure to show the effective date on which group coverage was reinstated. Reinstatement of coverage after termination may take place at the **employer's discretion** in accordance with the company's personnel policies.

Please refer to Recordkeeping section of this kit for more information on Enrollment.