Supplemental Term Life Insurance Enrollment Form

Group Plan: GL-674263

EMPLOYER INFORMATION	EMPLOYER'S FULL LEGAL NAME:			
	EMPLOYER'S LOCATION			
ENROLLMENT INFORMATION	*Please check one of the following:*			
	☐ INITIAL ENROLLMENT			EFFECTIVE DATE:
	☐ CHANGE TO EXISTING ENROLLMENT			EFFECTIVE DATE:
	☐ FAMILY STATUS CHANGE **(TYPE):**			EFFECTIVE DATE:
EMPLOYEE INFORMATION	EMPLOYEE NAME *(last, first, middle initial)*	DATE OF BIRTH	EMPLOYEE SSN	DATE OF HIRE
	ADDRESS	CITY	STATE	ZIP CODE
	EMAIL ADDRESS	HOME PHONE	CELL	OFFICE PHONE
	EARNINGS (AS DEFINED BY THE POLICY) $______________ ☐HR ☐MO ☐YR	Marital Status: ☐Single ☐Married ☐Divorced ☐ Widowed		

APPLICABLE BENEFIT ELECTIONS	*Choose one of the following Options:*		
	SUPPLEMENTAL LIFE		
	EMPLOYEE	☐ **Option 1:** Any amount from $10,000 to $500,000 (in increments of $10,000) not to exceed 5 times your annual salary. $ ______________ ☐ **Decline Coverage**	
	For Employee Supplemental Life amounts over the Guarantee Issue Amount ($150,000), Evidence of insurability Health Statement may be required.		
	CHILD	☐ **Yes,** Any amount from $2,000 to $10,000 (in increments of $2,000). $ Amount Per Child ______________ (dependent child(ren)coverage will end the last day in the year in which they turn age 19. Coverage continues until age 25 if full time student -proof required)	☐ **Decline Coverage**

CHILD'S NAME	☐M ☐F	DOB:	SSN:
CHILD'S NAME	☐M ☐F	DOB:	SSN:
CHILD'S NAME	☐M ☐F	DOB:	SSN:
CHILD'S NAME	☐M ☐F	DOB:	SSN:

SUPPLEMENTAL LIFE INSURANCE RATES (per **$1,000** of coverage)		
AGE	EMPLOYEE RATE	DEPENDENT CHILD RATE
< 25	$0.08	$0.07
25-29	$0.08	
30-34	$0.11	
35-39	$0.13	
40-44	$0.19	
45-49	$0.27	
50-54	$0.38	
55-59	$0.70	
60-64	$0.80	
65-69	$1.28	
70+	$2.07	
Your Supplemental Life Insurance benefit will be reduced by 35% on the date you attain age 66 and 50% when you attain age 70.		
Your Supplemental Life Insurance premium will continue to increase as you age. This will be based on the age chart above.		

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BENEFICIARY INFORMATION

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.

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

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE
ADDRESS			PHONE NUMBER	
NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE
ADDRESS			PHONE NUMBER	

CONTINGENT BENEFICIARY

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE
ADDRESS			PHONE NUMBER	
NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE
ADDRESS			PHONE NUMBER	

The beneficiary for insurance on the lives of your dependent children will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life insurance may be changed upon written request.

SIGNATURE	DATE

This plan includes Suicide Exclusion for employee and dependents. It applies to coverage amounts which become effective within two years of the date of death.

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 Insurance Company. I also understand that as I age, my premium rate will increase based on the Supplemental Life rates table.

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.

I authorize payroll deductions from my wages to cover my cost of coverage when applicable.

SIGNATURE	DATE