

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

200 Hopmeadow Street
Simsbury, Connecticut 06089
(A stock insurance company)



ENROLLMENT FORM			
EMPLOYER INFORMATION	EMPLOYER'S FULL LEGAL NAME		GROUP POLICY#
ENROLLMENT INFORMATION	Please check one of the following:		
	<input type="checkbox"/> INITIAL ENROLLMENT	EFFECTIVE DATE:	
	<input type="checkbox"/> CHANGE TO EXISTING ENROLLMENT	EFFECTIVE DATE:	
	<input type="checkbox"/> FAMILY STATUS CHANGE (TYPE):	EFFECTIVE DATE:	
EMPLOYEE INFORMATION	EMPLOYEE NAME	DATE OF BIRTH	EMPLOYEE ID/SSN
	ADDRESS	CITY	STATE
	SPECIALTY/OCCUPATION	EARNINGS (AS DEFINED BY THE POLICY) \$ <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	# HOURS WORKED PER WEEK
DEPENDENT INFORMATION	SPOUSE'S NAME	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
	CHILD'S NAME	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
	CHILD'S NAME	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
	CHILD'S NAME	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
	CHILD'S NAME	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
APPLICABLE BENEFIT ELECTIONS	Please make your benefit elections by checking the appropriate box. Contact your employer for plan details.		
	SHORT TERM DISABILITY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	For DISABILITYFLEXSM choose:		
	WEEKLY BENEFIT CHOICE \$	BENEFIT DURATION	BENEFIT COMMENCEMENT PERIOD
	LONG TERM DISABILITY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	BASIC LIFE AND AD&D*		
	EMPLOYEE	<input type="checkbox"/> YES \$	<input type="checkbox"/> NO
	SPOUSE	<input type="checkbox"/> YES \$	<input type="checkbox"/> NO
	CHILD	<input type="checkbox"/> YES \$	<input type="checkbox"/> NO
	*If applicable, the accidental death benefit (AD&D) will equal the face amount of the life insurance elected.		
	SUPPLEMENTAL LIFE AND AD&D*		
	EMPLOYEE	<input type="checkbox"/> YES \$	<input type="checkbox"/> NO
	SPOUSE	<input type="checkbox"/> YES \$	<input type="checkbox"/> NO
	CHILD	<input type="checkbox"/> YES \$	<input type="checkbox"/> NO
	*If applicable, the accidental death benefit (AD&D) will equal the face amount of the life insurance elected.		
SUPPLEMENTAL AD&D			
EMPLOYEE	<input type="checkbox"/> YES \$	<input type="checkbox"/> NO	
SPOUSE	<input type="checkbox"/> YES \$	<input type="checkbox"/> NO	
CHILD	<input type="checkbox"/> YES \$	<input type="checkbox"/> NO	

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies is Simsbury, CT

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.

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

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

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

SPOUSAL CONSENT SIGNATURE	DATE
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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 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 Louisiana and Maryland:

Any person who knowingly (knowingly and willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly and 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.

EMPLOYEE SIGNATURE

DATE