



Basic and Supplemental Life / AD&D Enrollment / Change Form



EMPLOYEE INFORMATION

Name		Soc Sec Number	
Address			
Date of Birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Hire	Banner ID

ENROLLMENT INFORMATION – EMPLOYEE COVERAGE

Type of Enrollment (check one): Initial Enrollment Change in coverage¹ Cancel Supplemental coverage Change beneficiary designation

REQUESTED AMOUNT

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Basic Life/AD&D only | <input type="checkbox"/> 1x annual salary – Supplemental Life/AD&D | <input type="checkbox"/> 2x annual salary – Supplemental Life/AD&D | <input type="checkbox"/> 3x annual salary – Supplemental Life/AD&D |
|---|--|--|--|

Rates for the Employee Supplemental Life/AD&D coverage are on the back of this form.

¹ You may need to provide evidence of good health that is satisfactory to Hartford Life before the coverage can become effective. This does not apply to coverage on children.

ENROLLMENT INFORMATION – DEPENDENT COVERAGE

Type of Enrollment (check one): Initial Enrollment Change in coverage¹ Cancel Supplemental coverage

REQUESTED AMOUNT (Life Only)	12-MONTH EMPLOYEE COST PER PAY	9-MONTH EMPLOYEE COST PER PAY
<input type="checkbox"/> No coverage	\$ 0.00	\$ 0.00
<input type="checkbox"/> \$20,000 Spouse/Domestic Partner and \$10,000 Per Child	\$ 2.25	\$ 3.00
<input type="checkbox"/> \$20,000 Spouse/Domestic Partner Only	\$ 1.50	\$ 2.00
<input type="checkbox"/> \$10,000 Per Child Only	\$ 0.75	\$ 1.00

BENEFICIARY DESIGNATION

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. If you need assistance, contact your benefits administrator or your own legal counsel. 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 “33% to Mary Jones, Mother and 67% to Edith Jones, Wife.” If a Trust is named, please indicate the date the Trust was established.

The beneficiary for Life/AD&D insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise, the estate of the spouse and children, subject to policy provisions.

Full Name	Address	Soc Sec Number	Relationship	Date of Birth	%
Primary					
Contingent					

I have been given the opportunity to enroll in the Supplemental Life/AD&D coverage. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and understand my request for coverage may be denied. I authorize my employer to make the appropriate payroll deductions from my wages. I understand the benefit I have elected is limited to the maximum benefit available under the policy. I further understand that the Supplemental Life plan only covers eligible dependents as defined under the insurance policy.

Signature	Date
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Life Insurance not available to all employee groups. See benefits handbook for eligibility information.