Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

County of Marin Benefits Enrollment Form

All Full-time Active Employees excluding Deputy Probation Officers, Probation Managers and Juvenile Corrections Officers

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter and/or check** your coverage elections. Make sure the coverage amount that you elect includes your existing coverage amount. You may only elect and will be covered for levels of coverage included in your employer's contract.
- **Step 2:** Please **sign, date and return** this form to **Human Resources**. Do not mail this form back to The Hartford's address indicated at the top of this form.

Information About You	
Employee Name:	**Employee ID (if not available, then Social Security Number):**
Date of Birth:	
Date of Hire:	

Dependent Information					**If more than 4 child(ren), attach additional sheet.**
Spouse Name (includes domestic partner):		**Gender:**	**Spouse Date of Birth:**	**Date of Marriage or Eligible Partnership:**	
		☐ M ☐ F			
Child Name:	**Gender:**	**Date of Birth:**	**Child Name:**	**Gender:**	**Date of Birth:**
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

Name: _____

_____	÷ 26 =	_____
Your Annual Earnings		Your Bi-weekly Gross Salary

Voluntary Long Term Disability Insurance – *60% of your pre-disability earnings up to monthly benefit maximum of $3,000*

If coverage amounts are based on earnings, your cost may change if your earnings change.

To calculate your pay period cost, please use the following formula(s):

_____	x	$0.0022	=	$ _____
Your Bi-Weekly Gross Salary		Rate		Bi-Weekly Cost Up To A Maximum Of $5.08

☐ I elect to **purchase** Long Term Disability coverage.
☐ I **decline** to purchase Long Term Disability coverage.

Supplemental Life and AD&D Insurance – *Please select only one of the following options:*

If coverage amounts are based on earnings, your cost may change if your earnings change.

To calculate your pay period cost, please use the following formula(s):

One times your annual earnings:

_____	x	$0.0035	=	$ _____
Your Bi-weekly Gross Salary		Rate		For 1x Bi-Weekly Premium

☐ I elect to **purchase** 1x Annual Earnings.
☐ I **decline** to purchase 1x Life and AD&D coverage.

Two times your annual earnings:

_____	x	$0.0070	=	$ _____
Your Bi-weekly Gross Salary		Rate		For 2x Bi-Weekly Premium

☐ I elect to **purchase** 2x Annual Earnings.
☐ I **decline** to purchase 2x Life and AD&D coverage.

Supplemental Dependent Life Insurance

☐ I elect to **purchase** $5,000 for my spouse and $1,500 for my child(ren) of Life coverage at a bi-weekly cost of
☐ $0.36. I **decline** to purchase Dependent Life coverage.

Name: _____

Beneficiary Designation

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

Primary Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:				**Phone Number:**
Primary Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:				**Phone Number:**

CONTINGENT BENEFICIARY

Contingent Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:				**Phone Number:**
Contingent Beneficiary Name:	**Social Security #:**	**Date of Birth:**	**Relationship:**	**Percentage:**
Address:				**Phone Number:**

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.

Signature of Employee's Spouse: _____ Date: _____

Name: _____

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 rates and benefits may be changed by the insurer.

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 Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

Signed _____ Date _____