HARTFORD LIFE INSURANCE COMPANY

ENROLLMENT FORM FOR PORTABILITY OF YOUR GROUP LIFE INSURANCE BENEFITS - FOR ALL STATES EXCEPT NEW YORK AND VERMONT -

EMPLOYER INSTRUCTIONS:

Employer: Complete Part A of the enrollment form, make a copy for your records and then give this enrollment form to the employee or employee's dependents whose coverage is terminating on or before the date of group coverage termination. **Please attach a complete enrollment history for the employee from the date of hire including prior carrier forms if applicable.** If you have any questions please call 1-877-320-0484.

Important Note: The employee must submit the completed enrollment form and first quarterly premium to the address listed below **within 31 days from the date of group coverage termination or 15 days from the employer's signature date on this form whichever is later. In no event, however, will this evnollment form period exceed 91 days from the date of group coverage terminates.**

Clear Form

Hartford Life and Accident Insurance Company
Attention: Portability Administration
P.O. Box 248108
Cleveland, OH 44124-8108

Part A (must be completed by Employer)

Policyholder Name	Group Policy Number

Check coverages to which portability is available:

- ☐ Basic Employee Life
- ☐ Supplemental Employee Life
- ☐ Basic Dependent Life
- ☐ Supplemental Dependent Life

Coverage is terminating for:

Name	Gender	Employee, Spouse or Child	Amount of In Force Basic Life Insurance (If portable)	Portability Cost per Quarter	Amount of In Force Supplemental Life Insurance (If portable)	Portability Cost per Quarter	Total Portability Cost per Quarter
	☐ M ☐ F						
	☐ M ☐ F						
	☐ M ☐ F						
	☐ M ☐ F						
	☐ M ☐ F						
						Grand Total:	

Reason for coverage termination

- ☐ Termination of Employment
- ☐ Employee no longer in an eligible class
- ☐ Death of the Employee
- ☐ Employee no longer eligible for dependent coverage
- ☐ Dependent ceases to be an eligible dependent
- ☐ Layoff
- ☐ Other _____

(May not be eligible to continue coverage)

Date Last Worked:	Date of Group	If coverage was extended beyond the date last work please provide the reason for the extension. (Please include any necessary documentation)	
Employee's Job Title: Coverage Termination:		Division or Location Employee Worked at: (If applicable)	
Date of Hire:	Base Annual Earnings:	How are Wages Paid? ☐ Hourly ☐ Salary	Employee's Union Status: ☐ Union ☐ Non Union

Note: A person is not eligible to continue group life insurance if he has reached his Defined Retirement Age under the 1983 amendments to the United States Social Security Act. Defined Retirement Ages under the 1983 amendments are as follows:

Year employee becomes 62	Defined Retirement Age	Year employee becomes 62	Defined Retirement Age
thru 1999	65	2017	66 + 2 months
2000	65 + 2 months	2018	66 + 4 months
2001	65 + 4 months	2019	66 + 6 months
2002	65 + 6 months	2020	66 + 8 months
2003	65 + 8 months	2021	66 + 10 months
2004	65 + 10 months	2022 +	67
2005-2016	66		

I understand that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement, is guilty (or may be guilty for residents of Oregon) of insurance fraud.

For residents of Pennsylvania, I understand that 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, any information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note: If the Accelerated Death Benefit was included in the terminating employee's policy with the group policyholder it will also be included in the employee's portability policy

Did you remember to please attach a complete enrollment history for the employee from the date of hire including prior carrier forms if applicable? ☐ Yes ☐ No

Policyholder/Employer Signature	Policyholder/Employer Name Printed	Date
Title	Telephone Numbe ( )	( )
r Fax Number		

Email Address

End of Employer Section

APPLICANT INSTRUCTIONS:

Applicant: Complete Part B of the enrollment form and make a copy for your records.

Each person electing to continue coverage must elect to continue either 100%, 75% or 50% of the amount of insurance for which they were insured for under the employer's plan as shown in PART A, rounded to the next higher $1,000 if not already a multiple thereof. In no event may an employee continue an amount of life insurance in excess of $250,000, or a spouse's continued amount of life insurance exceed $50,000, or a child's continued amount of life insurance exceed $10,000. No person's continued amount of life insurance may be less than $5,000 unless a dependent child.

In order for a dependent child to continue coverage, the former employee or employee's dependent spouse must elect to continue their coverage also.

First quarterly premium must be remitted with this enrollment form. The first quarterly premium required for each eligible person to continue 100% of their in-force coverage is shown in Part A. If 75% or 50% of insurance is desired, the premium should be prorated accordingly by multiplying by .75 or .5 respectively. Please make your check or money order payable to "Hartford Life and Accident Insurance Company". Do not send cash.

Important Note: The employee must submit the completed enrollment form and first quarterly premium to the address listed below within 31 **days from the date of group coverage termination or 15 days from the employer's signature date on this form whichever is later. In no event however, will this enrollment form period exceed 91 days from the date group coverage terminates.**

Hartford Life and Accident Insurance Company
Attention: Portability Administration
P.O. Box 248108
Cleveland, OH 44124-8108

Important Note: You may want to take the following information into consideration when deciding whether to apply for portability of coverage. Coverage under the group portability policy reduces and terminates upon reaching certain ages. Employee and spouse coverage reduces to 25% when reaching age 65. If you are age 65 or older when electing portability, your coverage will be immediately reduced to 25% of the amount that is eligible for portability. Additionally, coverage terminates when reaching age 75. A dependent child's coverage will terminate at age 19 unless they are a full time student, then coverage will terminate at age 25. Conversion is available upon reduction and termination of portability coverage. If you have questions about completing this enrollment form, you may call Hartford Life and Accident Insurance Company at 1-877-320-0484.

PART B (to be completed by applicant)

Employee Name:			
Address:	Town	State	Zip Code
Daytime Phone Number: ( )	Evening Phone Number ( )		

Is any applicant **converting** any portion of coverage which terminated? ☐ Yes ☐ No
If yes, answer the following questions:

Who?	Basic or Supplemental Life Insurance?	Amount Being Converted?

Coverage is requested to be continued for:

Name	Date of Birth	Social Security Number	Percentage of Insurance 50,75,100	Amount of Basic Life Insurance (If portable)	Portability Cost per Quarter	Amount of Supplemental Life Insurance (If portable)	Portability Cost per Quarter	Total Portability Cost per Quarter
			%					
			%					
			%					
			%					
							Grand Total:	

BENEFICIARY DESIGNATIONS:
Your prior group beneficiary designations do not apply to this coverage. You must identify the designated beneficiaries for all persons applying for coverage, except dependent children. The beneficiary for dependent children will automatically be the employee, if continuing coverage, or if the employee is not continuing coverage, the spouse.

It is important that your beneficiary designations be clearly understood. Hartford Life Insurance Company will consider all named beneficiaries to share equally in the proceeds unless you specify otherwise. To allocate a specific amount to a particular beneficiary, state the percentage, or share, next to that person's name.

You may also designate beneficiaries to be "primary" or "contingent". **Primary** beneficiaries are the persons who will receive the proceeds upon your death. **Contingent** beneficiaries are the persons who will receive the proceeds if the primary beneficiaries predecease you.

If your beneficiary is a trust, clearly indicate the name of the trust, and trustee if known, as well as the date the trust was established.

If you need assistance, contact your own legal counsel.

Insured	Beneficiary (ies)	Beneficiary's Social Security Number	Relationship	Age if Minor	Share	Primary or Contingent
Example: James Smith	Sally Smith Susie Smith	XXX XX XXXX XXX XX XXXX	Wife Daughter	 10	100% 100%	Primary Contingent
Employee Name	1. 2. 3.				% % %	
Spouse Name	1. 2. 3.				% % %	

End of Employee Section

I request to participate in the Hartford Group Insurance Trust in order to receive group life insurance. I have read this enrollment form and agree that all statements and answers are true and complete.

I understand that if any information stated in this enrollment form is incorrect, coverage may be rescinded and Hartford Life and Accident Insurance Company has no obligation to return any premium paid; except that for residents of New Hampshire, premium must be refunded. I understand that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement, is guilty (or may be guilty for residents of Oregon) of insurance fraud.

For residents of Pennsylvania, I understand that any person who knowingly and with intent to defraud any insurance company or other person, files an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I understand that no coverage will become effective until the enrollment form and premium amount has been approved and premiums have been received by Hartford Life and Accident Insurance Company.

Employee's Signature_____ Date _____

Spouse's Signature_____ Date _____
(If Applicable)

End of Employee Section