Group Benefits from The Hartford

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

Seton Hall University - Class 1 - Staff
Benefits Enrollment Form

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:	**Class:** 1	**Earnings:**
Location/Department/Division:		

Name: _____

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**	

Supplemental Life Insurance

If coverage amounts are based on earnings, your cost may change if your earnings change. Your cost may also change when you move into a new age category. You can purchase supplemental life insurance in increments of 1 times your annual earnings up to 3 times your annual earnings. The maximum amount you can purchase cannot be more than 3 times your annual earnings or $200,000.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0277	0.0277	0.0369	0.0577	0.0785	0.1269	0.1985	0.3208	0.3877	0.6138	1.0846	1.8185

To calculate your bi-weekly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $_____
Life Benefit Amount | Rate | Bi-weekly Cost

☐ I elect to **purchase** $_____ of life coverage.
☐ I **decline** to purchase life coverage.

Spouse Supplemental Life Insurance

Costs are based on the employee's age. Your cost may change when the employee moves into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0277	0.0277	0.0369	0.0577	0.0785	0.1269	0.1985	0.3208	0.3877	0.6138	1.0846	1.8185

To calculate your bi-weekly cost, please use the following formula(s):

$5,000 ÷ $1,000 = _____ x _____ = $_____
Life Benefit Amount | Rate | Bi-weekly Cost

☐ I elect to **purchase** $_____ of life coverage.
☐ I **decline** to purchase life coverage.

Child(ren) Supplemental Life Insurance

☐ I elect to **purchase** $5,000 of life coverage at a bi-weekly cost of $0.20 (cost is for all covered children).
☐ I **decline** to purchase life coverage.

Name: _____

Supplemental Accidental Death & Dismemberment Insurance

Family Member(s) Covered:	Employee Only	Employee & spouse only	Employee & children only	Employee, spouse & child(ren)
Percent of Benefit Paid:	100%	100% for employee 60% for spouse	100% for employee 15% for each child	100% for employee 50% for spouse 10% for each child

Coverage Option:	**Rate:**
Myself only:	$0.0106
Myself and my family:	$0.0148

To calculate your bi-weekly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $_____

Elected Benefit Amount (Employee Coverage Amount Only) | Rate | Bi-weekly Cost

☐ I elect to **purchase** $_____ of AD&D coverage for myself only.

☐ I elect to **purchase** $_____ of AD&D coverage for myself. My family will be covered at the percentages of my election listed above.

☐ I **decline** to purchase AD&D coverage.

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:**	

Name: _____

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.

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.

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_____