THE HARTFORD SUPPLEMENTAL BENEFITS ENROLLMENT FORM

Employee Information (If Enrolling OR Declining) ***Only Name and EMP ID needed if declining***		
Employer:	Job Title:	
Name:	Date of Hire:	EMP ID:
Email:	Phone:	
Social Security Number:	Date of Birth:	Gender:
Spouse/Domestic Partner Demographic Information (If Enrolling)		
Spouse/DP Name:	Relationship: Spouse / Domestic Partner	
Social Security Number:	Date of Birth:	Gender:

Child(ren) Demographic Information (If Enrolling)			
Child Name	SSN	DOB	Gender

SUPPLEMENTAL TERM LIFE INSURANCE

Employee Supplemental Term Life Insurance - $10,000 Increments

Minimum Election Amount: $10,000
Maximum Election Amount: $200,000 Guaranteed Issue; $500,000 with appoved Evidence of Insurability (EOI)

*Guaranteed Issue coverage is only available during an employee's initial eligibility period. **Any later applications made by employees who waived coverage during their initial eligibility period OR requests to increase coverage will be subject to Evidence of Insurability (EOI) and may be denied.**

	I wish to **ELECT** supplemental term life insurance for myself. **For election amounts above $200,000 ONLY -** I have attached a completed Evidence of Insurability form.**ELECTION AMOUNT: $_____ AD&D Automatically Added**
	I wish to **DECLINE** supplemental term life insurance for myself. **I understand that any subsequent applications will be subject to Evidence of Insurability (EOI) and may be denied.**

Spouse/Domestic Partner Supplemental Term Life Insurance - $5,000 Increments

Minimum Election Amount: $5,000
Maximum Election Amount: $30,000 Guaranteed Issue; $250,000 with appoved Evidence of Insurability (EOI)
* Spouse/Domestic Partner life insurance election cannot be greater than 50% of the employee's election amount.

	I wish to **ELECT** supplemental term life insurance for my spouse/DP. **For election amounts above $30,000 ONLY** - I have attached a completed Evidence of Insurability form. **ELECTION AMOUNT: $_____ AD&D Automatically Added**
	I wish to **DECLINE** supplemental term life insurance for my spouse/domestic partner. **I understand that any subsequent applications will be subject to Evidence of Insurability (EOI) and may be denied.**

Child Supplemental Term Life Insurance - Flat $10,000 (enrollment available to age 26)

*Employee must enroll in supplemental term life insurance in order to enroll child(ren). Cost is the same no matter how many children are enrolled.

	I wish to **ELECT** $10,000 of supplemental term life insurance for the child(ren) listed on this form and confirm that they are my biological child(ren) or child(ren) over whom I have custody. **AD&D Automatically Added**
	I wish to **DECLINE** $10,000 of supplemental term life insurance for my child(ren). **I understand that any subsequent applications will be subject to Evidence of Insurability (EOI) and may be denied.**

LONG TERM DISABILITY INSURANCE

Employee Only - Benefit Amount: 60% of salary, benefit begins to pay after 180 days of disability

	I wish to **ENROLL** in Long Term Disability Insurance.
	I wish to **DECLINE** Long Term Disability Insurance. **I understand that any subsequent applications will be subject to Evidence of Insurability (EOI) and may be denied.**

ACCIDENTAL INJURY INSURANCE

Accidental Injury Insurance - No Pre-Existing Condition Exclusions or Evidence of Insurability (EOI) Needed

	I wish to **ENROLL** in Accidental Injury Insurance at the coverage level indicated below: Employee Only ◯ / Employee + Child(ren) ◯ / Employee + Spouse/Domestic Partner ◯ / Employee + Family ◯
	I wish to **DECLINE** Accidental Injury Insurance.

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity Insurance - No Pre-Existing Condition Exclusions or Evidence of Insurability (EOI) Needed

	I wish to **ENROLL** in Hospital Indemnity Insurance at the coverage level indicated below: Employee Only ◯ / Employee + Child(ren) ◯ / Employee + Spouse/Domestic Partner ◯ / Employee + Family ◯
	I wish to **DECLINE** Hospital Indemnity Insurance.

CRITICAL ILLNESS (SPECIFIED DISEASE) INSURANCE

Critical Illness (Specified Disease Insurance) - No Pre-Existing Condition Exclusions or Evidence of Insurability (EOI) Needed

*If electing coverage, please indicate below whether you would like the **$10,000** benefit, **$20,000** benefit, or **$30,000** benefit.

	I wish to **ENROLL** in **$**_____ of Critical Illness (Specified Disease) Insurance at the coverage level indicated below: Employee Only ◉ / Employee + Child(ren) ◯ / Employee + Spouse/Domestic Partner ◯ / Employee + Family ◯
	I wish to **DECLINE** Critical Illness (Specified Disease) Insurance.

BENEFICIARY INFORMATION

Name:	_____%	Primary ◯ / Contingent ◯	DOB:	Gender:
Address:			Phone:	
Name:	_____%	Primary ◯ / Contingent ◯	DOB:	Gender:
Address:			Phone:	
Name:	_____%	Primary ◯ / Contingent ◯	DOB:	Gender:
Address:			Phone:	
Name:	_____%	Primary ◯ / Contingent ◯	DOB:	Gender:
Address:			Phone:	

IMPORTANT ELIGIBILITY INFORMATION

ACCIDENTAL INJURY, HOSPITAL INDEMNITY, AND CRITICAL ILLNESS (SPECIFIED DISEASE) INSURANCES ARE SUPPLEMENTAL TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THESE PLANS DO NOT CONSTITUTE QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. THEREFORE, YOU MUST BE ENROLLED IN HEALTH INSURANCE (THROUGH THE COUNTY OR ANOTHER PROVIDER) TO BE ELIGIBLE TO ENROLL IN THESE SUPPLEMENTAL BENEFITS.

Under New York law, you cannot have insurance for more than seven (7) specified diseases, even if these are from different insurers and you cannot be covered for the same disease under multiple policies. The Hartford's specified disease insurance includes seven (7) specified diseases. Therefore, if you already have a specified disease policy or application(s) pending, insurance will not be issued unless you replace your other insurance, or rescind your application(s) pending as of the date of enrollment.

SIGNATURE: _____ **DATE:** _____