GROUP BENEFITS

City of Manchester
Life and Disability Enrollment Form (Status Change)

THE HARTFORD

Information About You

Name:		Social Security Number / Employee ID Number:	
Date of Birth:	Date of Hire:	Type of Status Change:	Date of Status Change:

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 and details. *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.

Employer Paid Long Term Disability Insurance

Employer Paid Long Term Disability Insurance helps replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as an elimination period of 180 days and as long as you remain disabled, the maximum time you can receive the benefit is 2 years. The coverage provided by City of Manchester provides you with income protection to replace up to 60% of your Earnings, to a maximum monthly benefit of $5,000 at no cost to you.

Optional Long Term Disability Insurance

You have the opportunity to enhance your coverage by enrolling in Optional Long Term Disability Insurance. Optional Long Term Disability Insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period, of 180 days, and as long as you remain disabled, you may receive the benefit until your Social Security Normal Retirement Age. This plan provides you with income protection to replace up to 60% of your Earnings to a maximum monthly benefit of $5,000. If you enroll during this enrollment period, your coverage is provided to you on a guaranteed issue basis – no medical information is required. If you enroll after this enrollment period, evidence of insurability will be required for all coverage amounts.

To calculate your cost based on 48 pay cycles annually, please use the following formula(s):

_____	÷ 12 =	_____	÷ 100 =	_____	x	$0.0460	=	_____
My Annual Earnings Maximum = $100,000		My Monthly Earnings				Rate		My Pay cycle Cost

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

Basic Life and AD&D Insurance

City of Manchester provides, at no cost to you, Basic Life and AD&D Insurance in an amount equal to 1 times your annual Earnings, rounded to the next higher $1,000, to a maximum of $50,000.

Supplemental Life Insurance

You can purchase Supplemental Life Insurance in increments of $25,000. The maximum amount you can purchase cannot be more than $300,000. If you elect an amount that exceeds the guaranteed issue amount of $150,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

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	$0.0200	$0.0200	$0.0225	$0.0300	$0.0400	$0.0550	$0.0950	$0.1625	$0.2225	$0.4175	$0.9475	$1.7475

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

Expertise without equal.
Benefits without burden.

Name: _____

To calculate your cost based on 48 pay cycles annually, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $ _____
Life Benefit Amount — Rate — My Pay cycle Cost

☐ I elect to **purchase** the total amount of $_____ in Life coverage.
☐ I **decline** to purchase Life coverage.
☐ I elect to **continue** my current Life coverage.

Spouse Supplemental Life Insurance

If you elect Supplemental Life Insurance for yourself, you may elect Spouse Supplemental Life Insurance in increments of $500. The maximum amount you can purchase cannot be more than the lesser of $150,000 or 50% of your Supplemental Life Insurance. If you elect an amount that exceeds the guaranteed issue amount of $20,000, your Spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

Costs are based on Spouse's age.

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	$0.0200	$0.0200	$0.0225	$0.0300	$0.0400	$0.0550	$0.0950	$0.1625	$0.2225	$0.4175	$0.9475	$1.7475

To calculate your cost based on 48 pay cycles annually, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $ _____
Life Benefit Amount — Rate — My Pay cycle Cost

☐ I elect to **purchase** the total amount of $_____ in Life coverage.
☐ I **decline** to purchase Life coverage.
☐ I elect to **continue** my current Life coverage.

First Name	Last Name	Gender	Date of Birth	Date of Marriage

Child(ren) Supplemental Life Insurance

If you purchase Supplemental Life Insurance for yourself, you may purchase Child(ren) Supplemental Life Insurance for your Dependent Child(ren) between the ages of 2 weeks and 23 years (25 years if a full time student) in the amount of $10,000. Child(ren) between the ages of 2 weeks to 6 months are limited to coverage in the amount of $500.

☐ I elect to **purchase** the total amount of $10,000 of Life coverage with each pay cycle cost at $0.43 (cost is for all covered Children).
☐ I **decline** to purchase Life coverage.
☐ I elect to **continue** my current Life coverage.

First Name	Last Name	Date of Birth	Gender

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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. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** 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.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percent-age
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your spouse and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or 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.

This will certify 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 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: _____

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life and Disability insurance coverage described in the Benefit Highlight Sheets and offered through City of Manchester.

I understand and agree that if I decline coverage now, but later decide to enroll, I will 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 the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your 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 is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

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 not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____

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