Supplemental Life Insurance for Employee and/or Dependents
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

THE HARTFORD

Instructions: 1) Enter all required information clearly to avoid questions regarding your intent.
2) Sign, date and return all pages of the form to the Benefits Unit of the Personnel Department.

EMPLOYEE INFORMATION

Name (FIRST MI LAST)			
Gender ☐M ☐F ☐Non-binary	**Date of Hire** (mm/dd/yyyy)	**Employee Payroll ID**	**Date of Birth** (mm/dd/yyyy)
Mailing Address			
City		**State**	**Zip Code**

You can purchase Supplemental Life and AD&D Insurance in increments of $25,000. The maximum amount you can purchase cannot be more than $300,000 ($500,000 for Physicians). If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of $125,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective. The premium amount(s) for you and your spouse/partner are based on your (employee) age; therefore, the premium amount(s) will change as you grow older. The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 70.

How to Calculate Your Cost

Coverage for Employee Only:	**Benefit Amount – Select One Option**					
	☐ $25,000	☐ $50,000	☐ $75,000	☐ $100,000	☐ $125,000	☐ $150,000
	☐ $175,000	☐ $200,000	☐ $225,000	☐ $250,000	☐ $275,000	☐ $300,000
					☐ $500,000 only Physicians Assoc.	

_____ ÷ $1,000 = _____ X $_____ = $_____
Benefit Amount — Rate — Semi-Monthly Cost

Employee Semi-Monthly Supplemental Life and AD&D Rates												
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	$0.0575	$0.0575	$0.0625	$0.0650	$0.0825	$0.1050	$0.1550	$0.2275	$0.3400	$0.6000	$0.9500	$0.9500

REVISED: 08/2024
COUNTY OF SANTA CRUZ/00093284

Supplemental Life Insurance

IMPORTANT Dependent Enrollment Information: You must enroll in supplemental life insurance coverage in order for your dependents to be eligible for supplemental life insurance coverage. No person may be insured: 1) as a Dependent and an Active Employee; or 2) as a Dependent of more than one Active Employee; under The Policy.

DEPENDENT INFORMATION

Spouse/Domestic Partner Name (FIRST MI LAST) ☐ **N/A**	**Social Security Number**

Date of Birth (mm/dd/yyyy)	**Date Married/Partnered (mm/dd/yyyy)**	**Gender** ☐ M ☐ F ☐ Non-binary

Coverage for Spouse/Domestic Partner:	**Benefit Amount – Select One Option**
	☐ $20,000
	☐ Decline Spouse/Partner Coverage

How to Calculate Your Cost

Spouse Semi-Monthly Supplemental Life and AD&D Rates												
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	$0.0400	$0.0400	$0.0450	$0.0475	$0.0650	$0.0875	$0.1375	$0.2100	$0.3225	$0.5825	$0.9325	$0.9325

_____ ÷ $1,000 = _____ X $_____ = $_____

Benefit Amount | Rate | Semi-Monthly Cost

Child Name (FIRST MI LAST)	**Social Security Number**	**Date of Birth (mm/dd/yyyy)**	**Gender**
			☐ M ☐ F ☐ NB
			☐ M ☐ F ☐ NB
			☐ M ☐ F ☐ NB
			☐ M ☐ F ☐ NB

If you purchase Supplemental Life and AD&D insurance for yourself, you may purchase Child(ren) Supplemental Life Insurance for your Dependent Child(ren) under the age of 26 in the amount of $5,000 or $10,000. Child(ren) between the age of Live Birth to 6 months are limited to coverage in the amount of $2,000.

Coverage for Child/Children:	**Benefit Amount – Select One Option**	**Semi-monthly Premium Amount** (Cost per 24 Pay Periods)
	☐ $5,000 for each child	$0.50 for all children
	☐ $10,000 for each child	$1.00 for all children
	☐ Decline Child(ren) Coverage	N/A

SUPPLEMENTAL LIFE INSURANCE BENEFICIARY DESIGNATION (ENSURE YOUR DESIGNATION IS CLEAR SO THERE IS NO QUESTION OF YOUR INTENT)

This designation is for **all** group insurance coverage issued by The Hartford for which benefits are payable to a beneficiary or survivor (as indicated by each specific policy) in the event of your death, unless otherwise requested by you in writing. This designation may be changed upon written request. **All** information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless percentages are stated below. The **percentages must total 100%** for all Primary Beneficiaries and 100% for all Contingent Beneficiaries. If you need to designate more beneficiaries than space will allow, please include the additional information on a separate paper and attach it to/submit it with this form, clearly stating your name. Please consult your benefits administrator or legal advisor for assistance or additional information.

Primary Beneficiary(ies) (PRIMARY BENEFICIARIES ARE FIRST IN LINE TO RECEIVE BENEFITS IF LIVING AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**DOB (mm/dd/yyyy)**	**SSN**	**Relationship**	**Percent** %
Mailing Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**DOB (mm/dd/yyyy)**	**SSN**	**Relationship**	**Percent** %
Mailing Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

Contingent Beneficiary(ies) (CONTINGENT(S) WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS ALIVE AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**DOB (mm/dd/yyyy)**	**SSN**	**Relationship**	**Percent** %
Mailing Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**DOB (mm/dd/yyyy)**	**SSN**	**Relationship**	**Percent** %
Mailing Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

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:**_____

CONFIRMATION & SIGNATURE

By signing below:

- I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.
- I understand and agree that: 1) If I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is complete and be approved for such coverage before it becomes effective; 2) My request for coverage may be denied by The Hartford; 3) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) This enrollment form along with the insurance policy, the insurance certificate, any riders or applications describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 6) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.
- I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.
- I have read and understand the "Important Notice – Fraud Warning Statements" that applies to my state of residence.

Employee Signature	**Date of Signature**

END OF FORM – PLEASE REVIEW THE "IMPORTANT NOTICE – FRAUD WARNING STATEMENTS" ON THE FOLLOWING PAGE

Supplemental Life Insurance for Employee and/or Dependents
Important Notice – Fraud Warning Statements
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Please read the statement that applies to your state of residence prior to signing the enrollment form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly 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 Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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 Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For residents of New Mexico and North Carolina: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be submit to civil fines and criminal penalties.

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 Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oregon: 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.