GROUP BENEFITS

State of Arizona
Benefits Enrollment Form – Former Elected Officials

TRUSTED 200 YEARS THE HARTFORD

Information About You

Name:	**Social Security Number:**
Date of Birth:	**Date of Hire:**
Address:	**Phone Number:**

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 a Human Resources Representative.

Basic Life and AD&D Insurance

You can purchase Basic Life and AD&D Insurance in the amounts of $5,000, $10,000, $12,000, or $15,000. This coverage is offered without requiring you to provide evidence of insurability.

☐ I elect to **purchase** the total amount of $5,000 in Life and AD&D coverage at a quarterly cost of $1.95.
☐ I elect to **purchase** the total amount of $10,000 in Life and AD&D coverage at a quarterly cost of $3.90.
☐ I elect to **purchase** the total amount of $12,000 in Life and AD&D coverage at a quarterly cost of $4.68.
☐ I elect to **purchase** the total amount of $15,000 in Life and AD&D coverage at a quarterly cost of $5.85.
☐ I **decline** to purchase Life and AD&D coverage.

Spouse & Child(ren) Dependent Life Insurance

If you elect Basic Life Insurance for yourself, you may elect Spouse Dependent Life Insurance and Child(ren) Dependent Life Insurance for any Dependents between the ages of 1 day and 26 years in the amounts of $2,000, $4,000, $6,000, $12,000, or $15,000. This coverage is provided without requiring evidence of insurability.

☐ I elect to **purchase** the total amount of $2,000 in Life coverage at a quarterly cost of $2.46.
☐ I elect to **purchase** the total amount of $4,000 in Life coverage at a quarterly cost of $4.92.
☐ I elect to **purchase** the total amount of $6,000 in Life coverage at a quarterly cost of $7.38.
☐ I elect to **purchase** the total amount of $12,000 in Life coverage at a quarterly cost of $14.76.
☐ I elect to **purchase** the total amount of $15,000 in Life coverage at a quarterly cost of $18.45.
☐ I **decline** to purchase Life coverage.

First Name	Last Name	Gender	Date of Birth	Date of Marriage (Spouse Only)

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: _____

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 the prior Elected Official's 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 Prior Elected Official 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 The Former Elected Official's Spouse: _____ Date: _____

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life and Accident insurance coverage described in the Benefit Highlight Sheets and offered through the State of Arizona.

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 The Hartford to direct bill me for the necessary premium payments.

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.

Signed _____ Date _____

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