

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

200 Hopmeadow Street
 Simsbury, Connecticut 06089
 (A stock insurance company)



**Foothill-De Anza Community College District
 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 Your Benefits Department by 10/10/2014. 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: | |

Buy-Up Long Term Disability Insurance

If coverage amounts are based on Earnings, your cost may change if your Earnings change.

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Your Annual Earnings Maximum} = \$179,991.00}{12} = \frac{\text{Your Monthly Earnings}}{100} = \text{Rate} \times \$0.0550 = \text{Monthly Cost}$$

- 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.

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.

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 is Simsbury, CT.

Form PA-9604

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**Prepare today.
 Help protect tomorrow.**

Name: _____

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 disability income coverage with The Hartford, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

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 Louisiana and Maryland:

Any person who knowingly (knowingly and willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly and 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 _____

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