Rev. 12/2024

Reset the Form

FOOTHILL-DE ANZA
Community College District

Universal Enrollment Form

Medical/Dental/Vision – For Active, Retiree, COBRA, Surviving Spouse Participants

FOR OFFICE USE ONLY: Plan Type_____ Plan Code_____ Coverage Code_____ Effective Date_____

Medial Regional Code: _____Region 1 _____Region 2 _____Region 3 _____Out of State

Retiree Annuity Status: ○ STRS Pension ○ PERS Pension CalPERS ID: _____

Plan Selection:

☐ **PERS Gold PPO (Blue Shield)** ☐ **PERS Platinum PPO (Blue Shield)** ☐ **Anthem Blue Cross Select HMO**	☐ **Anthem Blue Cross Traditional HMO** ☐ **Blue Shield Access+ HMO** ☐ **Blue Shield Trio HMO**	☐ **Kaiser Permanente HMO** ☐ **Peace Officers Research Assoc of CA** ☐ **UnitedHealthcare SignatureValue Alliance**	☐ **UnitedHealthcare SignatureValue Harmony** ☐ **Western Health Advantage HMO**	☐ **Delta Dental*** ☐ **VSP*** ☐ **Employee Assistance Program*** * Not applicable for Part-Time Employees.

Employee Information:

Name (Last, First, M.I.)	CWID	Date of Birth	Date of Hire

Permanent Home Address (No PO Box)	Home Phone: Alternative Phone:

Sex	Marital Status	Classes of Coverage:
○ Female ○ Male ○ Other: _____ Hrs worked per week _____	○ Single ○ Divorced ○ Married ○ Legal Separation Date of Marriage or Registration of Domestic Partnership _____ Job Title _____ Campus Location: _____	☐ FT Faculty ☐ Confidential ☐ PT Faculty ☐ Police OE3 ☐ Classified ACE ☐ Administrator ☐ Classified CSEA ☐ Board Member ☐ Supervisor – TEAMSTERS ☐ Retirees ☐ Surviving Spouse ☐ COBRA Enrollees

Are you or your spouse covered under a CalPERS medical plan through another employer? ☐ Yes ☐ No
If yes, who is covered: ☐ Yourself ☐ Spouse ☐ Children
Name of the other CalPERS Agency: _____

	Medical		**Dental & Vision(excluding PT)**
☐	Employee Only	☐	Employee Only
☐	Employee + Spouse	☐	Employee + Spouse
☐	Employee + Domestic Partner*(DP/CA Registered)	☐	Employee + Domestic Partner*(DP/CA Registered)
☐	Employee + Child	☐	Employee + Child
☐	Employee + Children	☐	Employee + Children
☐	Employee + Family	☐	Employee + Family
☐	Employee + DP* + DP's Child(ren)	☐	Employee + DP* + DP's Child(ren)
☐	Employee + DP* + EE's Child(ren)	☐	Employee + DP* + EE's Child(ren)
☐	WAIVED	☐	WAIVED

** In order to have the rights provided by State law to registered domestic partnerships, you must be registered with California's statewide registry.*

This Election is for:		COBRA/Surviving Spouse Qualifying Event Date:	
☐	New Enrollment		Date:_____
☐	Marriage/Divorce	☐	Termination of Employment
☐	Name Change	☐	Divorce or Legal Separation
☐	Birth of Child	☐	Dependent reached age limit according to plan
☐	Adoption or Placement of Adoption/Court Ordered Coverage	☐	Change of Employment Hours
☐	Deleting Dependent(s)	☐	Marriage of Covered Child
☐	Loss of Other Health Coverage.	☐	Death of Subscriber
☐	Reinstatement of Coverage – Return from Unpaid Leave	☐	Retirement(when ineligible for District-paid benefits)
☐	Relocation(Moving out of service area)	☐	Unpaid Leave
☐	COBRA Continuation		
☐	Other:_____		

Medical / Dental / Vision Coverage

(A)dd (C)hange (D)elete	Relationship	Name (Last, First, M.I.)	SSN	Date of Birth	Sex	Children 26 and over, IRS Dependent?	Disabled?
	Self					N/A	N/A
	Spouse/DP					N/A	N/A
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No

Have you included stepchildren as dependents? ☐ YES ☐ NO If "yes", please indicate name(s):

_____

Do your stepchildren reside with you? ☐ YES ☐ NO

Are they dependent upon you for support and maintenance? ☐ YES ☐ NO

(Note: if you have more than three Child, please attached a separate sheet of paper with the above information.)

Do you or your dependents have other health coverage? If yes, please complete this section.

	Name	Other Insurance Carrier	Effective Date
Self			

Medicare Section (Applicable to retirees only)

Do you have Medicare? ☐ Yes ☐ No
If yes ……Part A ☐ Yes ☐ No
……Part B ☐ Yes ☐ No

Do any of your dependents have Medicare? ☐ Yes ☐ No
If yes for your dependents ……Part A ☐ Yes ☐ No
……Part B ☐ Yes ☐ No

Name(s) of Medicare Dependent(s):

_____

If yes for Medicare for you and/or your Dependent(s), please provide your and/or their Medicare ID and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

Medicare ID(Self): _____
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ Other

Effective Date of Medicare: _____

Medicare ID(Dependent): _____
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ Other
Effective Date of Medicare: _____

HEALTH BENEFITS WAIVER (Only Complete when waive)

- I do not wish to enroll in any of the health plans offered by the District
- I understand that if I wish to enroll in one of the District plans in the future, I can do so only during the annual Open Enrollment period or have a Life-Qualifying Event (LQE).

Therefore, I hereby elect to decline enrollment for health coverage for myself and my dependents under Foothill-De Anza CCD CORE (Medical/Dental/Vision) benefits plan. I understand that I will not be eligible for health benefits during the coming policy year and that this election will remain in effect until the next annual open enrollment period.

Employee Signature: _____ Date:_____

Payroll Deduction Contributions

The plan administrator may reduce or cancel the amount of my payroll deduction contributions or otherwise modify this agreement if this becomes necessary to satisfy certain provisions of the Internal Revenue Code. The amount of my monthly payroll deduction contributions is shown on a schedule that has been provided to me and the amount may change in the future.

I understand that any premiums I am obligated to pay for health care coverage for myself and/or any of my dependents will be deducted from my pay on a PRE-TAX basis.

I understand and agree that if I have a 10-month or 11-month assignment, my premium contribution will be collected at the earliest opportunity, and may be assessed in arrears to bring my contributions up-to-date.

I further understand and agree that in an event that any month in which a premium contribution is due and I have insufficient funds to meet my premium contribution, or whenever I am on non-pay status with paid benefits status such as LTD, etc., I may enroll under the Direct Pay Plan to avoid a lapse of coverage. In such situation, I must prepay the insurance carrier directly for the full monthly health insurance premium and qualify for the monthly employer share of cost reimbursement in arrears providing that I serve the District with appropriate proof of payment and applicable invoice to validate the payment.

Arbitration Agreement:

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I

may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

Authorization:

I acknowledge that I have received and read the enrollment materials for the Employee Benefits Program and I have read the information on this form. I acknowledge that the information submitted represents my enrollment choice(s) and I am authorizing contributions to be withheld from my pay for the healthcare covered selected.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 subjects such person to criminal and civil penalties.

This signature also verifies the accuracy of the information on this form.

I have read, understand, and agree to the terms and conditions above.

Employee Signature: _____ **Date:_____**

CalPERS

Health Benefits Plan Enrollment for Active Employees (HBD-12)

Health Account Management Division
P.O. BOX 942715
Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | TTY (877) 249-7442
FAX (800) 959-6545
www.calpers.ca.gov

SECTION A: Applicant Information

1. **Employee Name:** *(First)* *(M.I.)* *(Last)*
2. **Hire Date:** (mm/dd/yyyy)
3. **CalPERS ID or Social Security Number:**
4. **Date of Birth:** *(mm/dd/yyyy)*
5. **Gender:** ☐ Male ☐ Female
6. **Residence Address:** *(Street)* *(City)* *(State)* *(ZIP)* *(County)*
7. **Mailing Address** (If different): *(Street)* *(City)* *(State)* *(ZIP)* *(County)*
8. **Use Work ZIP Code for Health Eligibility**: ☐ Yes ☐ No *If yes, enter zip code here: (ZIP)*
9. **E-mail Address:**
10. **Primary Phone:** **Alternate:**

SECTION B: Type of Action

11. ☐ Enroll in a Health Plan ☐ Add/Delete Dependents ☐ Change Health Plan ☐ Cancel All Coverage ☐ Decline Coverage

SECTION C: Type of Permitting Event

12. ☐ New Employee ☐ New Contracting Agency ☐ Marriage or Domestic Partnership Date *(mm/dd/yyyy)*: ☐ Open Enrollment ☐ Move
☐ Delete Dependent Due to Death ☐ Divorce or Domestic Partnership Termination ☐ Birth/ Adoption ☐ Other:
13. **Permitting Event Date**: (mm/dd/yyyy)
14. **Name of Health Plan**: (If changing health plans, list new plan name)

SECTION D: Subscriber and Dependent Information (List yourself and all of your dependents to be enrolled on your health plan)

15. Name (First, M.I., Last)	Relationship Code *1	Gender	Date of Birth (mm/dd/yyyy)	CalPERS ID or Social Security Number	Action	Primary Care Physician
	SELF	☐ Male ☐ Female			☐ Add ☐ Delete	
		☐ Male ☐ Female			☐ Add ☐ Delete	
		☐ Male ☐ Female			☐ Add ☐ Delete	
		☐ Male ☐ Female			☐ Add ☐ Delete	
		☐ Male ☐ Female			☐ Add ☐ Delete	
		☐ Male ☐ Female			☐ Add ☐ Delete	

*1 Relationship Codes: **S** - Spouse **DP** - Domestic Partner **NC** - Natural Child **SC** - Step Child **AC** - Adopted Child **DPC** - Domestic Partner Child **PCR** - Parent Child Relationship

SECTION E: Enrollment

16. **To enroll, carefully review the information in this section and check the box:**

☐ **I ELECT TO ENROLL** in (or **MAKE CHANGES TO**) a health benefits plan as indicated above and agree to authorize deductions from my salary to cover my share of the cost of enrollment as it is now or as it may be in the future. **I CERTIFY** that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan. **I AGREE** to read the associated Evidence of Coverage (EOC) and any subsequent EOCs in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all the terms and conditions of the EOC and the Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

17. **To decline, carefully review the information in this section and check the box:**

☐ **I DECLINE ENROLLMENT** into the CalPERS Health Program for myself and my dependents.

I UNDERSTAND that if I choose to enroll at a later date, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in the CalPERS Health Program. Furthermore, if I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the Program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the month following the 90 day waiting period or the OE effective date.

18. **Employee Signature:**
19. **Date:** *(mm/dd/yyyy)*

SECTION F: CalPERS Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose
The information requested is collected pursuant to the Government Code Sections (20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to perform its functions regarding your status.

Please do not include information that is not requested.

SSN
Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction / state contributions
3. Billing of contracting agencies for employee / employer contributions
4. Reports to the CalPERS system and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals, complaints, or grievances with health plan carriers

Information Disclosure
Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights
You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy, or your rights, please write the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call our Customer Contact Center at 888-CalPERS (888-225-7377).

SECTION G: Privacy Information

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security account number to inform the individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and State benefits. Furthermore, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

The CalPERS health program uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contribution for State employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, change of address, marriage, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

SECTION H: For Employer Use

Please retain original signed form and all supporting documentation or affidavits in employee file. DO NOT send to CalPERS.

20. **Agency Name:**	21. **Date of Hire**: *(mm/dd/yyyy)*	22. **Retirement System**: ☐ CalPERS ☐ CalSTRS ☐ Other
23. **CalPERS Employer ID:**	24. **Division ID:**	25. **Employee Bargaining Unit/Employee Group:**
26. **Payroll Office:** ☐ State Controller's Office ☐ Non Central ☐ Public Agency Billing	27. **Date Received by Employer:**	28 **Effective Date:** *(mm/dd/yyyy)*

I hereby certify under the penalty of perjury that I am a duly appointed, qualified and acting Health Benefits Officer (HBO) of the above named agency, and the payment by the agency as provided by Section 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

29. **Health Benefits Officer:** (Print name)	30. **Signature:**	31. **Date:** *(mm/dd/yyyy)*	32. **Phone Number:**

33. **Remarks:**

2025 Employee Monthly Contribution Rates	
CalPERS PLANS*	**Per Month Contribution**
PERS Platinum PPO	
Single	$213.00
2 Party	$416.00
Family	$541.00
PERS Gold PPO	
Single	$153.00
2 Party	$296.00
Family	$385.00
KAISER HMO	
Single	$169.00
2 Party	$328.00
Family	$426.00
Anthem Select HMO	
Single	$187.00
2 Party	$364.00
Family	$472.00
Anthem Traditional HMO	
Single	$217.00
2 Party	$424.00
Family	$550.00
Blue Shield Access+ HMO	
Single	$178.00
2 Party	$345.00
Family	$448.00
Blue Shield Trio HMO	
Single	$158.00
2 Party	$306.00
Family	$397.00
UnitedHealthCare Signature Alliance HMO	
Single	$180.00
2 Party	$349.00
Family	$454.00

*Includes Dental and Vision

NOTE: Check Plan availability for your geographic area

2025 Employee Monthly Contribution Rates	
CalPERS PLANS*	**Per Month Contribution**
UnitedHealthCare Harmony HMO	
Single	$157.00
2 Party	$303.00
Family	$394.00
Western Health Advantage HMO	
Single	$137.00
2 Party	$264.00
Family	$343.00
PORAC	
Single	$156.00
2 Party	$340.00
Family	$426.00

*Includes Dental and Vision

NOTE: Check Plan availability for your geographic area

Flexible Spending Account Enrollment Form

Discovery Benefits
simplify.®

Step 1: Participant Information

*=Required Fields

*Employer Name (Do not abbreviate)

*Employee ID Number

*Participant Name (First, MI, Last)

*Social Security Number

*Participant Mailing Address

Email Address (If provided, all notifications will be sent via email)

*City

*State

*Zip

Day Telephone

*Birth Date (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

*Pay Frequency (**Please circle one**):
Monthly / Semi-Monthly / Bi-Weekly (24) / Bi-Weekly (26) / Weekly / Other

Gender (**Please circle one**): Male/Female

Marital Status (**Please circle one**): Married/Single

Step 2: Employee Premiums

If you have a payroll deduction for insurance premiums, eligible premiums will be deducted before taxes are calculated. You will automatically be enrolled in this portion of your Section 125 Plan. However, if you wish, you may opt out of the Employee Premium Conversion part of the Plan by contacting your HR Department and filling out the waiver form. *Please Note: Insurance premiums are not eligible for reimbursement with your Medical or Limited Medical Spending Account.

Step 3: Enrollment and Election Information

*Enrollment Type **(Please circle one)**: Open Enrollment Period / New Hire

	Medical Spending Account *Limit set by employer*	**Dependent Care Account** *Limit set by employer up to IRS maximum*	**Limited FSA** *(If applicable)*
***Annual Election**	$		
***Number of Pay Periods** (*Note: If enrolling mid-year, please enter the number of remaining pay periods within the plan year*)	÷		
***Per Pay Period Amount** *(To be deducted each pay period)*	=		
***Date of First Payroll** *(mm/dd/yyyy)*			
***Participant Effective Date** *(mm/dd/yyyy)*			

Step 4: Optional Services

Please select only one. Check with your employer as to which services your plan offers.

	Debit Card	A debit card pays directly from your Flexible Spending Account at the point-of-sale. Itemized receipts are required for all transactions that are not auto-substantiated at the point-of-sale.
	Auto-EOB	Auto-EOB is the automatic crossover of eligible health claims from a participant's health insurance carrier. Payment is made automatically to you from your Flexible Spending Account.

Step 5: Authorization or Refusal

**Please select only one.*

Participant Authorization
I authorize my employer to reduce my pay on a per pay period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

Participant Refusal
I do not want to participate. I understand that by refusing to participate, I will be unable to enroll this plan year unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit the change within a reasonable amount of time as deemed by the IRS and my employer.

*Employer Signature *(Not required during open enrollment)*

*Date

*Participant Signature

*Date

This page intentionally left blank.

Group Benefits from The Hartford

HARTFORD LIFE INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

THE HARTFORD

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 Employee Benefits Department. 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:	
Position:	

Dependent Information					If more than 4 child(ren), attach additional sheet.
Spouse Name (includes domestic partner):		**Gender:**	**Spouse Date of Birth:**	**Date of Marriage or Eligible Partnership:**	
		☐ M ☐ F			
Child Name:	**Gender:**	**Date of Birth:**	**Child Name:**	**Gender:**	**Date of Birth:**
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

Name: _____

Supplemental Life and AD&D Insurance

Your cost may change when you move into a new age category.

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	0.1200	0.1200	0.1500	0.1600	0.2100	0.3100	0.5000	0.7800	1.1900	2.2300	3.5900	3.5900

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

_____ ÷ $1,000 = _____ x _____ = $_____
Life and AD&D Benefit Amount | Rate | Monthly Cost

☐ I elect to **purchase** $_____ of life and AD&D coverage.
☐ I **decline** to purchase life and AD&D coverage.
☐ I elect to **continue** my current life and AD&D coverage.

Spouse Supplemental Life Insurance

Costs are based on the employee's age. Your cost may change when the employee moves into a new age category.

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	0.1000	0.1000	0.1300	0.1400	0.1900	0.2900	0.4800	0.7600	1.1700	2.2100	3.5700	3.5700

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

_____ ÷ $1,000 = _____ x _____ = $_____
Life Benefit Amount | Rate | Monthly Cost

☐ I elect to **purchase** $_____ of life coverage.
☐ I **decline** to purchase life coverage.
☐ I elect to **continue** my current life coverage.

Child(ren) Supplemental Life Insurance

☐ I elect to **purchase** $10,000 of life coverage at a monthly cost of $3.14 (cost is for all covered children).
☐ I **decline** to purchase life coverage.
☐ I elect to **continue** my current life coverage.

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. 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.

This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you. A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time you die.

Name: _____

PRIMARY BENEFICIARY

Primary Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	
Primary Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	

CONTINGENT BENEFICIARY

Contingent Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	
Contingent Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

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.

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 life insurance coverage with The Hartford, I understand and agree that my life insurance benefit(s) reduce at a specified age(s) stated in the policy.

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

Name: _____

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_____