GROUP BENEFITS FROM THE HARTFORD

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

THE HARTFORD

ENROLLMENT FORM

EMPLOYER INFORMATION	EMPLOYER'S FULL LEGAL NAME: Battenkill Valley Supervisory Union		GROUP POLICY#: 0GL 677964
ENROLLMENT INFORMATION	Please check one of the following:		
	☐ INITIAL ENROLLMENT		EFFECTIVE DATE:
	☐ CHANGE TO EXISTING ENROLLMENT		EFFECTIVE DATE:
	☐ FAMILY STATUS CHANGE (TYPE):		EFFECTIVE DATE:

EMPLOYEE INFORMATION					
EMPLOYEE NAME		DATE OF BIRTH	EMPLOYEE ID/SSN		DATE OF HIRE
ADDRESS		CITY	STATE	ZIP CODE	GENDER ☐ M ☐ F
SPECIALTY/OCCUPATION	EARNINGS (AS DEFINED BY THE POLICY) $ ☐HR ☐ MO ☐YR		# HOURS WORKED PER WEEK		LOCATION

INSTRUCTIONS

Please enter all required information clearly.

- **Step 1:** Please enter 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 the Central Office.**

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 90 days. The coverage provided by Battenkill Valley Supervisory Union 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.

Basic Life and AD&D Insurance

Battenkill Valley Supervisory Union provides, at no cost to you, Basic Life and AD&D Insurance in the amount equal to $20,000.

Supplemental Life Insurance

You can purchase Supplemental Life Insurance in increments of $10,000. The maximum amount you can purchase cannot be more than $400,000. If you elect an amount that exceeds the guaranteed issue amount of $480,000, you will need to provide evidence of good health 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	0.0600	0.0600	0.0800	0.0900	0.1000	0.1500	0.2400	0.4300	0.6600	1.2700	2.0600	2.6300

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

_____ (Life Benefits Amount) + $1,000 = _____ X _____ (Rate) = $ _____ (My Monthly Cost)

☐ I elect to purchase $ _____ of Life coverage.

☐ I decline to purchase 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. This beneficiary designation will be for ALL groups 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.

Prepare today.
Help protect tomorrow.™

	NAME

BENEFICIARY INFORMATION

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.

PRIMARY BENEFICIARY

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

CONTINGENT BENEFICIARY

NAME	SOCIAL SECURITY #	DATE OF BIRTH	RELATIONSHIP	PERCENTAGE

ADDRESS	PHONE NUMBER

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 Insurance may be changed upon written request.

This will represent that, as spouse of the employee named, 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

I acknowledge that I have been given the opportunity to enroll in the Life Insurance coverage described in the master agreement and offered through Battenkill Valley Supervisory Union.

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. 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 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.

SIGNED	DATE