

GROUP BENEFITS

Jefferson County American Federation of Teachers Benefits Enrollment Form



Information About You

Name:	32979-0	Social Security Number / Employee ID Number:
Date of Birth:		Date of Hire:
Earnings:		Location/Department/Division:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **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 Human Resources.

Voluntary Long Term Disability Insurance

You have the opportunity to enroll in Voluntary Long Term Disability Insurance. Voluntary Long Term Disability Insurance helps to 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 the elimination period, of 180 days. This plan provides you with income protection to replace up to 60% of your Earnings, to a maximum monthly benefit of \$6,000. If you enroll during this enrollment period, your coverage is provided to you on a guaranteed issue basis – no medical information is required. If you enroll after this enrollment period, evidence of insurability will be required for all coverage amounts.

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	0.0990	0.1110	0.2690	0.3740	0.4490	0.6520	0.8180	0.9430	0.7880	0.7560	0.7560	0.7560

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

$$\frac{\text{Your Annual Earnings}}{\text{Maximum} = \$120,000} \div 12 = \frac{\text{Your Monthly Earnings}}{\text{Rate}} \div 100 = \text{Rate} \times \text{Rate} = \$ \text{My Monthly Cost}$$

- ☐ I elect to **purchase** Long Term Disability coverage.
- ☐ I **decline** to purchase Long Term Disability coverage.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Disability Insurance coverage described in the Benefit Highlight Sheets and offered through Jefferson County American Federation of Teachers.

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 my employer to make the appropriate payroll deductions from my earnings.

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 not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____

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Jefferson County American Federation of Teachers
Generic Newly Eligible Full Language

**Prepare Today.
Help Protect Tomorrow.**