

# If You Became Disabled, Would Your Paycheck be Protected?

You're probably aware of the importance of insuring your life, home and car. But what about your paycheck? What would you do if you became disabled with a serious illness or injury and could no longer work for months – or even years? Without a regular paycheck, could you afford to pay your mortgage/rent and other monthly bills, fund your children's education expenses or save for retirement?

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## Long Term Disability Insurance



An Affordable  
Way to Protect  
Your Paycheck

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# INCOME PROTECTION FROM THE HARTFORD

Florida  
Department of  
Transportation

## Long-Term Disability Benefit Highlights

<b>What is Long-Term Disability Insurance?</b>	<p>Long-Term Disability Insurance pays you a portion of your earnings if you cannot work because of a disabling illness or injury.</p> <p>This highlight sheet is an overview of your Long-Term Disability Insurance. Once you have elected and been approved for coverage, a certificate of insurance will be available to explain your coverage in detail.</p>
<b>What is disability?</b>	<p>Disability is defined in The Hartford's* policy with your employer. Typically, disability means that you cannot perform the essential duties of your occupation due to injury, sickness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are 80% or less than of your pre-disability earnings.</p> <p>Once you have been disabled for 36 months, you must be prevented from performing the essential duties of any occupation and as a result, your current monthly earnings are 60% or less than of your pre-disability earnings.</p>
<b>Am I eligible?</b>	You are eligible if you are an active employee who works at least 30 hours per week on a regularly scheduled basis.
<b>How much coverage would I have?</b>	<p>You may purchase coverage that would pay you a benefit of 60% of your earnings. The maximum Long-Term Disability benefit you could receive is \$5,000 per month. Your plan includes a minimum benefit of 10% of your earnings or \$100 per month.</p> <p>Earnings are defined as in The Hartford's policy with your employer.</p>
<b>When can I enroll?</b>	You may enroll during the first 60 consecutive days of employment or during an open enrollment period.
<b>When is it effective?</b>	Coverage goes into effect subject to the terms and conditions of the policy.
<b>How long do I have to wait before I can receive my benefit?</b>	You must be disabled for at least 90, 180 or 365 days; depending on the coverage plan you elect and are approved for, before you can receive a Long-Term Disability benefit payment.
<b>Are there other limitations to enrollment?</b>	Employees electing to decrease their existing elimination period (i.e. changing from Option 3 to Option 2) and employees electing LTD coverage for the first time must complete the Simplified Medical Underwriting (SMU) Form during this enrollment. Voluntary coverage will be approved, or additional information will be requested based on each individual's responses.
<b>I already have Disability coverage; do I have to do anything?</b>	If you are not changing the amount of your coverage, you do not have to do anything. If you want to purchase Long-Term Disability insurance for the first time or change to a shorter elimination period, you must complete the Simplified Medical Underwriting (SMU) Form during this enrollment, as explained in the previous section.
<b>Can the amount of my benefit be reduced?</b>	Yes. As described below, your monthly Long-Term benefit may be reduced by other income you receive.

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.

<b>How long will my disability payments continue?</b>	For as long as you remain disabled, LTD benefit payments will continue according to the following schedule:									
	Age at Disability	Prior to age 62	62	63	64	65	66	67	68	69+
	Option 1	To age 65	4 years	3 ½ years	3 years	2 ½ years	2 ¼ years	2 years	1 ¾ years	1 ½ years
	Option 2 & 3	To age 65	3 ½ years	3 years	2 ½ years	2 years	1 ¾ years	1 ½ years	1 ¼ years	1 year

## Important Details

The following is an overview of your Long-Term Disability Insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

**Exclusions:** You cannot receive Long-Term Disability benefit payments for disabilities that are caused or contributed to by:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability

You must be under the regular care of a physician to receive benefits.

### Mental Illness, Alcoholism and Substance Abuse:

- You can receive benefit payments for Long-Term Disabilities resulting from mental illness, alcoholism and substance abuse for a total of 24 months for all disability periods during your lifetime.
- Any period of time that you are confined in a hospital or other facility licensed to provide medical care for mental illness, alcoholism and substance abuse does not count toward the 24 month lifetime limit.

**Pre-existing Conditions:** Your insurance limits the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your policy, you will be covered for a disability due to that condition only if:

- You have not received treatment for your condition for the 365 day period before the effective date of your insurance, or
- You have received no further treatment for that condition for 180 consecutive days from the date your coverage begins, or
- You have been insured under this coverage for 365 consecutive days prior to your disability commencing, so you can receive benefits even if you're receiving treatment.

For example, if you currently take prescription drugs for a heart condition, you would be insured for a disability caused by your heart condition if you went treatment free for 180 consecutive days from your effective date, or, you would be insured for a disability caused by your heart condition after you have been insured under the policy for 365 consecutive days.

Your benefit payments **will be reduced** by other income you receive or are eligible to receive due to your disability, such as:

- Social Security Disability Insurance (please see next section for exceptions)
- Workers' Compensation
- Other employer-based Insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan.)

Your benefit payments **will not be reduced** by certain kinds of other income, such as:

- Retirement benefits if you were already receiving them before you became disabled

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- Retirement benefits that are funded by your after-tax contributions
- The portion of your Long -Term Disability payment that you place in an IRS-approved account to fund your future retirement.
- Your personal savings, investments, IRAs or Keoghs
- Profit-sharing
- Most personal disability policies
- Social Security increases

This Benefit Highlights Sheet is an overview of the Long-Term Disability Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the Insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your Insurance coverage. In the event of any difference between the Benefit Highlights Sheet and the Insurance policy, the terms of the Insurance policy apply.

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Underwritten by:  
Hartford Life and Accident Insurance Company  
Simsbury, CT 06089

# FLORIDA DEPARTMENT OF TRANSPORTATION

## Voluntary Long Term Disability Insurance Enrollment Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Bi-weekly Salary: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

People First ID #: \_\_\_\_\_

Employees electing to decrease their existing elimination period (i.e. changing from Option 3 to Option 2) and employees electing LTD coverage for the first time must complete the Simplified Medical Underwriting (SMU) Form during the enrollment. Voluntary coverage will be approved, or additional information will be requested based on each individual's responses.

Use the rate chart and calculation line below to determine your bi-weekly cost for this coverage.\*

Please indicate the LTD option you wish to elect below (Section I), AND complete the calculation line (Section II).

### I. LTD Options

I elect to **enroll** in the Voluntary LTD:

I elect to **change my option** in the Voluntary LTD to:

**Option 1 Plan (90 day elimination period)**

Your Age	Under 40	40-49	50+
Your Rate	\$.0055	\$.0082	\$.0110

**Option 1 Plan (90 day elimination period)**

Your Age	Under 40	40-49	50+
Your Rate	\$.0055	\$.0082	\$.0110

**Option 2 Plan (180 days elimination period)**

Your Age	Under 40	40-49	50+
Your Rate	\$.0046	\$.0069	\$.0092

**Option 2 Plan (180 days elimination period)**

Your Age	Under 40	40-49	50+
Your Rate	\$.0046	\$.0069	\$.0092

**Option 3 Plan (365 days elimination period)**

Your Age	Under 40	40-49	50+
Your Rate	\$.0040	\$.0059	\$.0079

**Option 3 Plan (365 days elimination period)**

Your Age	Under 40	40-49	50+
Your Rate	\$.0040	\$.0059	\$.0079

### II. Calculation Line

1. Enter your bi-weekly salary: \$ \_\_\_\_\_

2. Enter your **Rate** from the chart above: \_\_\_\_\_

3. Multiply (1) by (2). This is your bi-weekly cost: \$ \_\_\_\_\_ \*

\*Once a year your deductions will be adjusted if there has been a change from one age bracket to the next, or if your bi-weekly pay has changed.

### Employee Confirmation

I have been given the opportunity to enroll in Florida Department of Transportation's LTD Insurance plans. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis (Miscellaneous Deduction Code 0434). I am not now disabled and I am performing all the duties of my occupation on a full-time basis.

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this enrollment form along with your completed Simplified Medical Underwriting form to:

Post Tax Benefits Office  
Department of Transportation  
605 Suwannee St, MS 50  
Tallahassee, Florida 32399-0450

Name: \_\_\_\_\_

# FLORIDA DEPARTMENT OF TRANSPORTATION

## Disability Simplified Medical Underwriting Application Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

**Instructions: Please complete the following questions by checking yes or no in the designated box. Upon completion, please sign and return this Simplified Medical Underwriting Form along with your completed Enrollment Application to the address indicated below.**

During the past 5 years has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for any of the following: heart condition; cancer; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; any disease of the joints, including neck and back disorders; any mental or nervous disorder; any disorder of the brain or nervous system; or have you been absent from work due to a chronic/recurrent reproductive system disorder?

Employee  Yes  No

During the past 5 years have you been declined for any disability insurance coverage?

Employee  Yes  No

### **NOTICE**

Any person who includes any false, deceptive or misleading information on an application or files a claim for payment of a loss or benefit, commits a fraudulent insurance act, and is subject to criminal and civil penalties where and to the extent allowed by state law. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, penalties may include imprisonment, fines, denial of insurance, and civil damages (in New York this may not exceed five thousand dollars).

This information may be used by the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company (for fully insured coverages) for plan administration purposes to decide if the person(s) is/are eligible for coverage.

Employee Address: \_\_\_\_\_

EMPLOYEE'S SIGNATURE (required)  
or Legal representative to Applicant

DATE SIGNED  
Relationship: \_\_\_\_\_

**PLEASE SIGN AND RETURN THIS SIMPLIFIED MEDICAL UNDERWRITING FORM ALONG WITH YOUR COMPLETED ENROLLMENT APPLICATION TO**  
POST TAX BENEFITS OFFICE  
DEPARTMENT OF TRANSPORTATION  
605 SUWANNEE STREET, MS 50  
TALLAHASSEE, FLORIDA 32399-0450