



Income Protection Benefits

Florida Department of Revenue
Benefits Enrollment Form

Information About You

Name:	Social Security Number:
Date of Birth:	Employee ID Number:
Annual Salary:	Date of Hire:

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 FLORIDA DEPARTMENT OF REVENUE, HUMAN RESOURCE SERVICES PROCESS, CARLTON BUILDING, ROOM 343, 501 S. CALHOUN STREET, TALLAHASSEE, FLORIDA 32399-0100.

Supplemental Life and AD&D Insurance

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	0.1200	0.1500	0.2100	0.3200	0.5100	0.8000	1.0400	1.6400	2.8800	4.8700

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

$$\frac{\text{Life and AD\&D Benefit Amount}}{\$1,000} = \text{Rate} \times \text{Rate} = \$ \text{My Monthly Cost}$$

- I elect to **enroll** for \$_____ of Life and AD&D coverage.
- I elect to **change** my current Life and AD&D coverage to \$_____.
- I elect to **cancel** my current Life and AD&D coverage.

Spouse Supplemental Life Insurance

Costs are based on your Spouse's age.

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	0.1100	0.1700	0.2800	0.4700	0.7600	1.0000	1.6000	2.8400	4.8300

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

$$\frac{\text{Life Benefit Amount}}{\$1,000} = \text{Rate} \times \text{Rate} = \$ \text{My Monthly Cost}$$

- I elect to **enroll** for \$_____ of Life coverage.
- I elect to **change** my current Life coverage to \$_____.
- I elect to **cancel** my current Life coverage.

First Name	Last Name	Gender	Date of Birth	Date of Marriage

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Expertise without equal.
Benefits without burden.™

Name: _____

Child(ren) Supplemental Life Insurance

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

$$\frac{\text{Life Benefit Amount}}{\$1,000} = \frac{\text{Rate}}{\$0.0600} = \$ \text{My Monthly Cost}$$

- I elect to **enroll** for \$_____ of Life coverage.
- I elect to **change** my current Life coverage to \$_____.
- I elect to **cancel** my current Life coverage.

Total Monthly cost of all coverage elected (Employee + Spouse + Child) \$_____

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 group 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.

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.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your spouse and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life insurance coverage described in the Benefit Highlight Sheets and offered through Florida Department of Revenue.

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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