TEAR ALONG PERFORATION AND MAIL IN SEPARATE ENVELOPE

ENROLLMENT FORM

HARTFORD VOLUNTARY AD&D

POLICY NUMBER: 21 ADD S05630

POLICYHOLDER: FLORIDA DEPARTMENT OF TRANSPORTATION

SELECT ONE: ☐ **NEW** **OR** ☐ **CHANGE**

EMPLOYEE NAME: LAST NAME, FIRST NAME, MI

_____

DATE OF EMPLOYMENT ____/____/____

DATE OF BIRTH ____/____/____

SOCIAL SECURITY # ___-___-____

EMPLOYEE ID # _____

AMOUNT OF YOUR PRINCIPAL SUM (AD&D BENEFIT)

$ _____

SELECT ONE:

☐ **PLAN I – EMPLOYEE ONLY**

☐ **PLAN II – EMPLOYEE AND FAMILY**

☐ **PLAN III – EMPLOYEE AND CHILDREN**

PRIMARY BENEFICIARY

_____

RELATIONSHIP _____

CONTINGENT BENEFICIARY

_____

RELATIONSHIP _____

☐ I authorize the premium for this insurance to be deducted from my salary.

☐ I do not wish to purchase coverage under this plan.

SIGNATURE

_____

DATE ____/____/____

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

SHADED AREA TO BE COMPLETED BY THE EMPLOYER

EFFECTIVE DATE OF COVERAGE:

BIWEEKLY PREMIUM:

MISC. DEDUCTION CODE:

Hartford Life

Underwritten by Hartford Life; Serviced and Marketed by
CAPITAL INSURANCE AGENCY, INC.