GROUP BENEFITS

Supplemental Life and AD&D Insurance

Benefit Fact Sheet for:

Florida Department of Revenue

Eligibility	You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.
Coverage Effective Date	Coverage goes into effect subject to the terms and conditions of the policy. In no case will newly elected benefits become effective sooner than on the date of hire. You must be Actively at Work with your employer on the day your coverage takes effect.
Enrollment Period	You must elect coverage within 31 days of your eligibility waiting period which is on the date of hire.
Benefit Amount	You can purchase Supplemental Life and AD&D Insurance in increments of $10,000. The maximum amount you can purchase cannot be more than the lesser of 5 times your annual Salary or $300,000. Annual Salary is as defined in The Hartford's contract with your employer.
AD&D Coverage	AD&D provides benefits due to certain injuries or death from an accident. The covered injuries or death can occur up to 365 days after that accident. The insurance pays: • 100% of the amount of coverage you purchase in the event of accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia. • 75% for paraplegia or triplegia (paralysis of three limbs). • One-half (50%) for accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia. • One-quarter (25%) for accidental loss of thumb and index finger of the same hand or uniplegia. Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage you purchase.
Guaranteed Issue Amount	You are eligible to enroll for coverage up to the guaranteed issue amount of $80,000 - *no medical information is required.* You must provide evidence of insurability and be approved by The Hartford to receive coverage above the guaranteed issue amount. You may need to complete a *Personal Health Application*. These are available from The Hartford or your employer.

Benefit Reductions	50% at age 70. All coverage cancels at retirement.
Spouse Supplemental Life Insurance	If you elect Supplemental Life and AD&D Insurance for yourself, you may choose to purchase Spouse Supplemental Life Insurance in increments of $5,000, to a maximum of $150,000. Coverage cannot exceed 50% of the amount of your Employee Voluntary/Supplemental Life Insurance coverage. You may not elect coverage for your Spouse if they are an active member of the armed forces of any country or international authority, or is already covered as an Employee under this policy. Your Spouse is guaranteed coverage of up to $30,000. Your Spouse must provide evidence of insurability and be approved by The Hartford to receive coverage above the guaranteed issue amount. Your Spouse may need to complete a *Personal Health Application*. These are available from The Hartford or your employer.
Child(ren) Supplemental Life Insurance	If you elect Supplemental Life and AD&D Insurance for yourself - You may choose to purchase Child(ren) Supplemental Life Insurance coverage in increments of $2,000 to a maximum of $10,000 for each Child– *no medical information is required*. You may not elect coverage for your Child if your Child is an active member of the armed forces of any country or international authority. • Child(ren) must be unmarried and are covered from 15 days to 19 years old or 25 years if they are a full-time student or meet certain other conditions. • Unmarried Child(ren) over age 19 may be covered if they are disabled and primarily dependent upon the Employee for financial support. • Child(ren) from 15 days to 6 months are limited to a reduced benefit of $100.
Conversion	You have the option of converting your group Life coverage to your own individual policy (policies).
Living Benefits Option	If you are diagnosed as having a terminal illness with a 12 month life expectancy, the Living Benefits Option allows you to receive an accelerated payment of a portion of your life Insurance. The option is available to individuals with at least $10,000 in group coverage from The Hartford and is subject to a maximum age limit of 60. You may request a minimum accelerated payment of $3,000 up to a maximum of 80% of your coverage not to exceed $300,000. Funds are paid directly to you, with no policy restrictions on how you use them. The remaining benefit is then payable to your beneficiary.
Waiver of Premium	This provision applies if you become totally disabled before 60 and your disability lasts for at least 9 months. You must provide proof of your condition within one year of your last day of work and once we approve, your coverage will continue without payment of premium up to Social Security Normal Retirement Age, as long as you remain totally disabled. The premium for your dependent's coverage will also be waived if you are disabled and approved for waiver of premium. Coverage for your dependents will end if the policy terminates. Payment of premium is required until waiver is approved by The Hartford.

Limitations and Exclusions

As is standard with most term life Insurance plans, death by suicide is covered only after the employee has been insured for two years. Therefore, if death results from suicide, no benefit will be payable for any Life coverage that became effective within two years of the date of death.

Other exclusions may apply depending upon your coverage. Refer to your policy.

This Benefit Fact Sheet is an overview of the 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 Fact Sheet and the Insurance policy, the terms of the Insurance policy apply.

Florida Department of Revenue
Hartford Life and Accident Insurance Company (HLA) Newly Eligible
Rev 03/08

GROUP BENEFITS

Florida Department of Revenue Benefits Enrollment Form

Information About You

Name: 39357-0	**Social Security Number / Employee ID Number:**
Date of Birth:	**Date of Hire:**
Salary:	**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 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

You can purchase Supplemental Life and AD&D Insurance in increments of $10,000. The maximum amount you can purchase cannot be more than 5 times your annual Salary or $300,000. If you elect an amount that exceeds the guaranteed issue amount of $80,000, 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	0.1000	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):

_____ ÷ $1,000 = _____ x _____ = $_____

Life and AD&D Benefit Amount | Rate | My Monthly Cost

☐ I elect to **purchase** $_____ of Life and AD&D coverage.

☐ I **decline** to purchase Life and AD&D coverage.

Spouse Supplemental Life Insurance

If you purchase Supplemental Life and AD&D Insurance, you can purchase Spouse Supplemental Life Insurance in increments of $5,000. The maximum amount you can purchase cannot be more than the lesser of $150,000 or 50% of your Employee Voluntary/Supplemental Life Insurance coverage. If you elect an amount that exceeds the guaranteed issue amount of $30,000, your Spouse will need to provide evidence of good health that is satisfactory to The Hartford before the excess can become effective.

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):

_____ ÷ $1,000 = _____ x _____ = $_____

Life Benefit Amount | Rate | My Monthly Cost

☐ I elect to **purchase** $_____ of Life coverage.

☐ I **decline** to purchase Life coverage.

Name:_____

First Name	Last Name	Gender	Date of Birth	Date of Marriage

Child(ren) Supplemental Life Insurance

If you purchase Supplemental Life and AD&D Insurance, you can purchase Child(ren) Supplemental Life Insurance for your Dependent Child(ren) between the ages of 15 days and 19 years (25 years if a full time student), in increments of $2,000. The maximum amount you can purchase cannot be more than $10,000. Child(ren) between the ages of 15 days and 6 months are limited to coverage in the amount of $100.

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

_____ ÷ $1,000 = _____ x _____ = $_____

Life Benefit Amount | Rate | My Monthly Cost

$0.0600

☐ I elect to **purchase** $_____of Life coverage.

☐ I **decline** to purchase Life coverage.

First Name	Last Name	Date of Birth	Gender

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.

Name:_____

Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Disclaimer: Spousal consent does not apply to ERISA plans.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life 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 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.

Signed _____Date _____