Group Benefits from The Hartford

Voluntary Long Term Disability Insurance

Benefit Highlights

Florida Department of Transportation

What is voluntary long term disability insurance?	Voluntary long term disability insurance pays you a portion of your earnings if you miss time at work because of a disabling illness or injury. This highlight sheet is an overview of your voluntary 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.
What is disability?	Disability is defined in The Hartford's contract with your employer. Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical conditions covered by the insurance, and as a result, your current monthly earnings are 80% or less than of your pre-disability earnings. Once you have been disabled for 36 months, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are 60% or less than of your pre-disability earnings.
Am I eligible?	You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.
How much coverage would I have?	You may purchase coverage that pays you a benefit of 60% of your earnings to a maximum monthly benefit of $5,000 per month. This plan includes a minimum benefit of $100 per month. Earnings are defined as in The Hartford's contract with your employer.
When can I enroll?	You can enroll during your scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of your eligibility waiting period as stated in your group policy.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. You must be actively at work with your employer on the day your coverage takes effect.
How long do I have to wait before I can receive my benefit?	To receive a voluntary long term disability insurance benefit payment, you must be disabled for at least: • Option 1: 3 months • Option 2: 6 months • Option 3: 12 months

Prepare today.
Help protect tomorrow.

Are there other limitations to enrollment?	The guaranteed issue amount is the amount of insurance that you may elect without providing evidence of insurability. If this is the first time you are eligible to elect coverage, evidence of insurability is not required. If you did not elect coverage the first time it was offered to you, evidence of insurability is required to elect coverage. Evidence of insurability is also required to make a change to enhance your current coverage.
I already have voluntary long term disability insurance coverage through my employer; do I have to do anything?	If you take no action, your coverage will automatically continue with The Hartford subject to the terms of the contract.
Can the duration or amount of my benefit be reduced?	Yes. Your benefit duration may be reduced once you reach certain ages as specified in The Hartford's contract with your employer. In addition, as described below within the important details, your monthly long-term benefit may be reduced by other income you receive.
How long will my disability payments continue?	If you become disabled prior to age 62, benefits may continue for as long as you remain disabled or until age 65. If your disability occurs at age 62 or above, the number of payments may reduce.

Important Details
The following is an overview of your voluntary 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 voluntary long term disability insurance 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 months 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 length of time specified in the contract before the effective date of your insurance, or
- you have been insured under this coverage for the length of time specified in the contract prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
- you have already satisfied the pre-existing condition requirement of your previous insurer.

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
- retirement benefits that are funded by your after-tax contributions
- 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 voluntary 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.

Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

Florida Department of Transportation

Benefits Enrollment Form

Instructions

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

- **Step 1:** Please **enter and/or check** your coverage elections. Make sure the coverage amount that you elect includes your existing coverage amount. 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 Bonnie Cook, Capital Insurance Agency, P.O. Box 15949, Tallahassee, FL 32317. Do not mail this form back to The Hartford's address indicated at the top of this form.

Information About You	
Employee Name:	**Employee ID (if not available, then Social Security Number):**
Date of Birth:	
Date of Hire:	

Voluntary Long Term Disability Insurance

If coverage amounts are based on earnings, your cost may change if your earnings change. Your cost may also change when you move into a new age category.

Option 1: This benefit begins after you have been disabled for the elimination period of 3 months.

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	0.2538	0.2538	0.2538	0.2538	0.3785	0.3785	0.5077	0.5077	0.5077	0.5077	0.5077	0.5077

To calculate your bi-weekly cost, please use the following formula(s):

_____	÷ 12 =	_____	÷ 100 =	_____	x	_____	= $	_____
Your Annual Earnings Maximum = $100,000.00		Your Monthly Earnings				Rate		Bi-weekly Cost

Option 2: This benefit begins after you have been disabled for the elimination period of 6 months.

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	0.2123	0.2123	0.2123	0.2123	0.3185	0.3185	0.4246	0.4246	0.4246	0.4246	0.4246	0.4246

Name: _____

To calculate your bi-weekly cost, please use the following formula(s):

_____	÷ 12 =	_____	÷ 100 =	_____	x	_____	= $	_____
Your Annual Earnings Maximum = $100,000.00		Your Monthly Earnings				Rate		Bi-weekly Cost

Option 3: This benefit begins after you have been disabled for the elimination period of 12 months.

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	0.1846	0.1846	0.1846	0.1846	0.2723	0.2723	0.3646	0.3646	0.3646	0.3646	0.3646	0.3646

To calculate your bi-weekly cost, please use the following formula(s):

_____	÷ 12 =	_____	÷ 100 =	_____	x	_____	= $	_____
Your Annual Earnings Maximum = $100,000.00		Your Monthly Earnings				Rate		Bi-weekly Cost

- ☐ I elect to **purchase** option 1 long term disability coverage.
- ☐ I elect to **purchase** option 2 long term disability coverage.
- ☐ I elect to **purchase** option 3 long term disability coverage.
- ☐ I **decline** to purchase long term disability coverage.
- ☐ I elect to **continue** my current long term disability coverage.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may 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 my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my 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 disability income coverage with The Hartford, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand rates and benefits may be changed by the insurer.

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 required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force.

Fraud Notice(s)
For Residents of Louisiana and Maryland:
Any person who knowingly (knowingly or willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly or willfully in Maryland) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New York (Not applicable to Life Insurance):
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Name: _____

For Residents of Virginia:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed_____ Date_____

Employer Group Benefits Coverage Information

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Please completely fill out Section 1 and Section 2 on this page and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Employees: Please completely fill out the Applicant Information section on the 2nd page even if you are not applying for coverage.

Section 1: Employer Details *(to be completed by Employer)* PLEASE PRINT CLEARLY

Employer Name: Florida Department of Transportation	Policy Number: 024614
Employer Mailing Address (Street, City, State, Zip Code):	
Division/Location/Subsidiary with Mailing Address *(if applicable):*	
Benefits Contact Name (First, Last):	
Benefits Contact Email Address:	Benefits Contact Phone:

Section 2: Employee Details *(to be completed by Employer)* PLEASE PRINT CLEARLY

Employee Name (First, MI, Last):	Date of Hire (mm/dd/yyyy):
Base Annual Earnings*:	Coverage Effective Date* (mm/dd/yyyy):

* As described in the contract with The Hartford

Disability Insurance Coverage Requested

- Check Yes if employee is requesting Long Term Disability coverage that is subject to EOI

Long Term Disability	☐ Yes, EOI is required

 FL

Employee: First Name _____ Middle Initial _____ Last Name _____

EVIDENCE OF INSURABILITY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155

Applicant Information

	First Name	Last Name	Social Security #	Gender	Height (ft./in.)	Weight (lbs.)*	Date of Birth (mm/dd/yyyy)
Employee				☐ Male ☐ Female			

* If currently pregnant, please provide pre-pregnancy weight

Employee	Street Address		Day Time Phone	
	City		Evening Phone	
	State, Zip Code		Email Address	

Medical Information

Each Applicant must answer each of the following questions to the best of their knowledge and belief.

	Employee
Within the past 5 years, have you tested positive for exposure to the HIV Infection or been diagnosed as having ARC or AIDS caused by the HIV Infection or other sickness or condition derived from such infection?	☐ Yes ☐ No
Have you been diagnosed or are you being treated by a licensed member of the medical profession for pregnancy?	☐ Yes ☐ No
Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 consecutive work days due to a disability, injury, or sickness?	☐ Yes ☐ No
Within the past 5 years, have you used any drugs or narcotics, with the exception of those taken as prescribed by your physician?	☐ Yes ☐ No
Within the past 5 years, have you been diagnosed or treated by a licensed medical professional for drug or alcohol abuse (excluding support groups)?	☐ Yes ☐ No
Within the past 5 years, have you been convicted of operating a motor vehicle while under the influence of drugs or alcohol?	☐ Yes ☐ No

Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for:

	Employee		Employee
Heart Disease (Do not check "Yes" if you only have High Blood Pressure or a Heart Murmur)	☐ Yes ☐ No	Disease, injury or surgery of Joint, Ligaments, Knee, Back, or Neck (including Arthritis)	☐ Yes ☐ No
Heart-Related Surgery or Heart Attack	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No
High Blood Pressure If you checked "Yes" to High Blood Pressure, have you had a change in medication within the last 6 months?	☐ Yes ☐ No ☐ Yes ☐ No	Hepatitis (Do not check "Yes" for Hepatitis A) or Cirrhosis	☐ Yes ☐ No

Medical Information (continued)

	Employee		Employee
Blocked Arteries (Arteriosclerosis, Atherosclerosis, Aneurysm, or Deep Vein Blood Clot)	☐ Yes ☐ No	Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)	☐ Yes ☐ No
Stroke or transient ischemic attack (TIA)	☐ Yes ☐ No	Alzheimer's or Parkinson's Disease	☐ Yes ☐ No
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	☐ Yes ☐ No	Paralysis	☐ Yes ☐ No
Diabetes	☐ Yes No	Major Organ Transplant	☐ Yes No
Depression	☐ Yes No	Chronic Fatigue Syndrome or Fibromyalgia	☐ Yes No
Sleep Apnea	☐ Yes ☐ No	Narcolepsy	☐ Yes ☐ No
Cancer (Do not check "Yes" for Basal Cell Carcinoma only) If "Yes", Date of Diagnosis:	☐ Yes ☐ No	Ulcerative Colitis or Crohn's Disease	☐ Yes ☐ No
Psychotic, Psychiatric, Personality, or Bi-Polar Disorder	☐ Yes ☐ No	Kidney Failure or Dialysis	☐ Yes ☐ No

Notice

To the best of your knowledge, you are required to notify Hartford Life and Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date the coverage is approved.

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, copies of medical records which you have authorized us to review, and information obtained from MIB, Inc. Only information that is relevant to determining Evidence of Insurability for the coverage which you are currently requesting will be considered.

Authorization

I, an undersigned applicant, authorize Hartford Life and Accident Insurance Company, together with its affiliates, ("Company") to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

In the event that I cannot be reached via telephone, I authorize a representative of the Company to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that he or she is calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company by telephone.

☐ Yes, you may leave a message as indicated above. ☐ No, please do not leave a message.

Employee: First Name _____ Middle Initial _____ Last Name _____

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize my employer, any health or benefits plan, physician, medical professional, hospital, clinic, laboratory, MIB Group, Inc. (MIB, Inc), pharmacy or pharmacy benefits manager that possesses my protected personal health information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), to furnish such protected health information to the Company or its representative. The Company may only use information disclosed under this authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

I authorize the Company to disclose the "PHI" in its files to its reinsurer(s) and affiliates, other insurance companies and their affiliates, other persons, representatives and/or organizations performing functions on behalf of the Company and their affiliates, my employer, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me that relates to this application and that such requested information and the identity of the source of the information shall be released to me or, in the case of medical information, to a licensed medical professional of my choice.

I/We authorize Hartford Life and Accident Insurance Company, or its reinsurers, to make a brief report of my/our personal health information to Medical Information Bureau.

I agree that a photocopy of this authorization is valid as the original and I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This authorization shall be valid for twenty-four (24) months from the date signed below. This authorization may be revoked upon written request to the Company, and will not remain valid beyond the date the revocation is received by the Company. I understand the revocation may be a basis for denying my insurance application, and that it does not alter the Company's right to use the application for purposes of determining misrepresentation once coverage has been issued.

I have received and read a copy of the Notice of Insurance Information Practices.

Fraud

For any Applicants that do not reside in the following states: Colorado, California, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of California: For your protection, California law requires the following to appear on this form: The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

For residents of Colorado: 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. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New York (Applicable to Accident and Health Insurance Only): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee: First Name _____ Middle Initial _____ Last Name _____

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

PRE-EXISTING CONDITIONS LIMITATION – Applicable to Accident and Health Insurance Only – For Residents of NY

With respect to group disability insurance, I understand that the policy/certificate may include a pre-existing condition provision that limits or excludes coverage for a period of time if I have a pre-existing condition as defined on the date my coverage becomes effective. I also understand that I may obtain additional information regarding this provision by referring to the group policy and/or certificate.

Certification

I hereby represent that I have reviewed the above questions and that all statements and answers contained herein are full, complete, and true to the best of my knowledge and belief. For residents of Virginia only: I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

This application will be made a part of the Policy.

_____ _____

Employee Signature Date Signed

Please mail the completed **Employer Group Benefits Coverage Information page** and **Evidence of Insurability** application to:

The Hartford

Group Medical Underwriting

P.O. Box 2999

Hartford, CT 06104-2999

If you have any questions or concerns, please call The Hartford Customer Service Department toll-free at 1-800-331-7234, Monday through Friday, 8:00 a.m. to 6:00 p.m., Eastern Time, or email us at medical.uw@thehartford.com.