

Administered by:

Underwriting Company  
(herein called the "Company"): \*

# VOLUNTARY / SUPPLEMENTAL LIFE WITH AD&D ENROLLMENT



- CNA Group Life Assurance Company
- Continental Assurance Company

⇒ IF YOU ARE:

- Enrolling during your employer's initial (not annual) enrollment period
- Enrolling within your eligibility period, and
- Enrolling for coverage amounts that are under the guaranteed issue limit (if applicable)

Then you may complete this form. If you have answered no to ANY of the above, ask your employer or Benefit Administrator for an Evidence / Proof of Insurability application.

## PART 1 – Employee Information POLICY #: \_\_\_\_\_

|                                      |            |  |               |   |
|--------------------------------------|------------|--|---------------|---|
| Name of Employee (Last, First, M.I.) |            | Social Security Number                 | Date of Birth | Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female |
| Street Address                       |            | Daytime Phone (Incl. Area Code)<br>( ) |               |   |
| (City, State, Zip Code)              |            | Evening Phone (Incl. Area Code)<br>( ) |               |   |
| Employer                             | Occupation | Date of Hire                           | Class         | Annual Salary<br>\$   |

## PART 2 – Coverage Election

Employee Life Coverage  
Amount Requested: \$ \_\_\_\_\_

**Note: If you are 65 or older, your benefit amount will be reduced immediately per the age reduction provision**

**Tobacco User?\***  Yes  No

Accidental Death & Dismemberment (AD&D)  
 1 times your life coverage amount  
 Other

**Refusal of Coverage:** This is to certify that I have been given an opportunity to participate in the Voluntary/Supplemental Group Life plan but have declined this coverage. I fully understand that I will not be entitled to any benefits under this coverage. I further understand that if I desire to participate at a later date, I must furnish, (at my own expense), evidence of insurability satisfactory to the Company before I may be insured under the plan. I understand that I may be turned down for coverage on the basis of my health.

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

**If you wish to include your Spouse and/or eligible Dependent Children, complete this section. If this is a Voluntary plan, Dependent life coverage is not available unless you enroll yourself for coverage.**

Dependent Life Coverage (AS INDICATED BELOW)

| Name of Spouse (First, Middle, Last)                                   | Gender (M / F) | Birth Date | Social Security # | Life Coverage Amount | Accident Coverage Amount |
|--|----------------|------------|-------------------|----------------------|--------------------------|
| Tobacco User? <input type="checkbox"/> Yes <input type="checkbox"/> No |                |            |                   |                      |                          |
| Name of Dependent Children (First, Middle, Last)                       | Gender (M / F) | Birth Date | Social Security # | Life Coverage Amount | Accident Coverage Amount |
|  |                |            |                   |                      |                          |
|  |                |            |                   |                      |                          |
|  |                |            |                   |                      |                          |
|  |                |            |                   |                      |                          |

\* The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company, Hartford Life Insurance Company and CNA Group Life Assurance Company (pending state approval of name change to "Hartford Life Group Insurance Company").

\*\* "Tobacco User" is an employee/spouse who has used one or more tobacco or nicotine products in the last 12 months. This question is used to determine the insurance rate if applicable to your policy. It is not used to determine eligibility or insurability.

**Effective Dates:** For this group insurance plan to become effective, a minimum number of employees must enroll. Your coverage will not go into effect unless the minimum requirement is met. AD&D and Dependent coverages will not become effective if the applicant is not eligible for such coverages under the group policy.

**EMPLOYEE AND/OR DEPENDENT COVERAGE IS SUBJECT TO ELIGIBILITY REQUIREMENTS.**

**Coverage amounts that exceed the guaranteed issue limit will require Evidence / Proof of Insurability.**

**PART 3 – Beneficiary Information**

Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone # & Address \_\_\_\_\_

Contingent Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone # & Address \_\_\_\_\_

You are the beneficiary for Dependent Life Coverage.

**Written consent is needed from** your spouse, if you are a resident of AZ, CA, ID, LA, NV, NM, TX, WA or WI and you name someone other than your spouse as beneficiary.

\_\_\_\_\_  
Signature of Spouse

\_\_\_\_\_  
Date

**I desire to participate in the Voluntary/Supplemental Life Insurance program as presented to me and hereby authorize my employer to make the necessary deduction from my wage or salary to pay my part of the premium.**

**I acknowledge** having read the Fraud Notice below.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

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**STATE FRAUD NOTICES**

**All states except CO, FL, NJ, and VA:** Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or settlement 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 subjects such person to criminal and civil penalties.

**CO:** 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.

**FL:** 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.

**NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**VA:** 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.