If you do not want to add additional life insurance coverage or change your beneficiary, no action is required.

Life Insurance

Life Insurance Rates

Life Insurance Enrollment Form

The Town of Harvard covers all benefit-eligible employees for a Basic Life (5K); employees may opt to add additional coverage. Additional coverage will be paid by the employee.

Life Insurance Rates

Supplemental Life Insurance with AD&D
All levels of coverage shown are paid by the employee (i.e., these are additional levels byond the $5000)

Supplemental Life for Employee

	Age							
Amount In addition of $5k	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$5,000	$0.35	$0.45	$0.60	$0.95	$1.55	$2.55	$4.00	$5.20
$10,000	$0.70	$0.90	$1.20	$1.90	$3.10	$5.10	$8.00	$10.40
$15,000	$1.05	$1.35	$1.80	$2.85	$4.65	$7.65	$12.00	$15.60
$20,000	$1.40	$1.80	$2.40	$3.80	$6.20	$10.20	$16.00	$20.80
$25,000	$1.75	$2.25	$3.00	$4.75	$7.75	$12.75	$20.00	$26.00
$30,000	$2.10	$2.70	$3.60	$5.70	$9.30	$15.30	$24.00	$31.20
$35,000	$2.45	$3.15	$4.20	$6.65	$10.85	$17.85	$28.00	$36.40
$40,000	$2.80	$3.60	$4.80	$7.60	$12.40	$20.40	$32.00	$41.60
Rate Per $1000	$0.07	$0.09	$0.12	$0.19	$0.31	$0.51	$0.80	$1.04

Supplemental Life for Spouse

	Age							
Amount In addition of $5k	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$2,500	$0.18	$0.23	$0.30	$0.48	$0.78	$1.28	$2.00	$2.60
$5,000	$0.35	$0.45	$0.60	$0.95	$1.55	$2.55	$4.00	$5.20
Rate Per $1000	$0.07	$0.09	$0.12	$0.19	$0.31	$0.51	$0.80	$1.04

Supplemental Dependent Life for Children ($2000/Child) and Baby ($100/Baby)

Number of Children (age 5 month through 19 years)

1	2	3	4	5
$0.14	$0.28	$0.42	$0.56	$0.70

Hartford Life and Accident Insurance Company

LIFE / DISABILITY ENROLLMENT FORM

☐ Initial ☐ Change ☐ Termination ☐ Reinstatement

THE HARTFORD

TO BE COMPLETED BY THE EMPLOYEE

Name: (Last Name, First Name & M.I.)			Birthdate (MM/DD/YYYY)
Social Security Number	Sex ☐ M ☐ F	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Date of Marriage (MM/DD/YY)

Employee Home Address: (Street, City, State & Zip Code)

Dependent Information (Complete only if dependent coverage is available and elected.) **(Last Name, First Name & M.I.)**	**Sex: M/F**	(DEPENDENT LIFE ONLY) **Birthdate (MM/DD/YYYY)**
Spouse (Indicate last name if different from Employee)	☐ M ☐ F	
Child	☐ M ☐ F	
Child	☐ M ☐ F	
Child	☐ M ☐ F	

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. (You will not be covered for coverages not included in your Employer 's contract.) To elect coverage check the box marked "Y" . To decline coverage check the box marked "N."

Basic Life	**Supplemental**	**AD/D**	**Supp. ADD**	**Weekly Disability**
☐ Y ☐ N AMT $	☐ Y ☐ N ☐ $ X Basic Amount Earnings ☐ Other $	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N ☐ Flat Amount

Dependent Life	**LTD**	**LTD Buy-Up**
Spouse ☐ Y ☐ N Amount $ Child ☐ Y ☐ N Amount $	☐ Y ☐ N	**Option 1** % **Option 2** %

Beneficiary Designation - Please refer to the reverse side of this form for important information regarding beneficiary designation.

	Full Name	Address	Social Security No.	Relationship	Date of Birth
PRIMARY:					
CONTINGENT:					

☐ I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed, and I authorize my Employer to make the appropriate deductions, if any, from my wages for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between The Hartford and my Group Plan.

☐ I hereby waive the coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to The Hartford, before my coverage will become effective.

Signature _____ **Date** _____

TO BE COMPLETED BY THE EMPLOYER

Policy Symbol	Policy Number	Bill Unit	Loss Unit:	Business Location:	Original Effective Date of Policy:
	691346				

Employer Name	Employee Hire Date	Effective Date of Coverage
TOWN OF HARVARD		
Employee Occupation	Employee Class	Life WD LTD

Salary $ ☐ Annual ☐ Monthly ☐ Weekly ☐ Hourly

Termination Date _____ Reinstatement Date _____

For Policyholders covered under Pennsylvania Long Term Disability policies: If, within 90 days immediately prior to becoming covered under the group contract, you or any dependent have received medical care or advice for a disease or physical condition, you, he or she may not be covered for such disease or physical condition until you, he or she has been covered for one year under this contract. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received within 90 days immediately prior to becoming covered under the group contract.

Hartford Life and Accident Insurance Company

THE HARTFORD

LIFE / DISABILITY ENROLLMENT FORM

☒ Initial ☐ Change ☐ Termination ☐ Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

Name: Last	First	M.I.	Birthdate (MM/DD/YYYY)
Doe	John	F.	09/09/1960

Social Security Number	Sex	Marital Status	Date of Marriage (MM/DD/YY)
XXX-XX-XXXX	☒ M ☐ F	☐ Single ☒ Married ☐ Widowed ☐ Divorced ☐ Separated	02/03/1997

Employee Home Address: Street	City	State	Zip Code
123 Any Lane	Anywhere	CT	11111

Dependent Information (Complete only if dependent coverage is available and elected.) Last	First	M.I.	Sex: M/F	(DEPENDENT LIFE ONLY) Birthdate (MM/DD/YYYY)
Spouse (Indicate last name if different from Employee) Doe	Jane	A.	☐M ☒F	07/26/1936
Child			☐M ☐F	
Child			☐M ☐F	
Child			☐M ☐F	

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. (You will not be covered for coverages not included in your Employer 's contract.) To elect coverage check the box marked "Y ." To decline coverage check the box marked "N."

Basic Life	Supplemental	AD/D	Suppl ADD	Weekly Disability
☒ Y ☐ N AMT $ 5,000.	☐ Y ☐ N ☐ _____ X Basic Amount Earnings ☐ Other _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N ☐ Flat Amount

Dependent Life	LTD	LTD Buy-Up
Spouse ☐ Y ☐ N Amount _____ Child ☐ Y ☐ N Amount _____	☒ Y ☐ N	Option 1 _____ % Option 2 _____ %

Beneficiary Designation - Please refer to the reverse side of this form for important information regarding beneficiary designation.

	Full Name	Address	Social Security No.	Relationship	Date of Birth
PRIMARY:	Jane Amy Doe	123 Any Lane Anywhere, CT 11111	XXX-XX-XXXX	Spouse	07/26/1963
CONTINGENT:	Mark James Doe	987 Ever Road Any Town, CT 22222	XXX-XX-XXXX	Brother	05/19/1964

☒ I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed, and I authorize my Employer to make the appropriate deductions, if any, from my wages for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between The Hartford and my Group Plan.

☐ I hereby waive the coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to The Hartford, before my coverage will become effective.

Signature John F. Doe Date 05/23/2007

TO BE COMPLETED BY THE EMPLOYER

Policy Symbol	Policy Number	Bill Unit	Loss Unit	Business Location	Original Effective Date of Policy
GL-GLT	22222222			CT	01/01/1993

Employer Name	Employee Hire Date	Effective Date of Coverage
ABC Company	10/16/1994	02/01/1998

Employee Occupation	Employee Class	Life	WD	LTD
Supervisior		01		01

Salary $ 43,500 ☒ Annual ☐ Monthly ☐ Weekly ☐ Hourly

Termination Date _____ Reinstatement Date _____

For Policyholders covered under Pennsylvania Long Term Disability policies: If, within 90 days immediately prior to becoming covered under the group contract, you or any dependent have received medical care or advice for a disease or physical condition, you, he or she may not be covered for such disease or physical condition until you, he or she has been covered for one year under this contract. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received within 90 days immediately prior to becoming covered under the group contract.