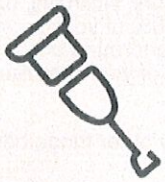
GROUP VOLUNTARY LONG-TERM DISABILITY INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD



Just over 1 in 4 of today's 20 year-olds will become disabled before they retire (age 67).[1]

PORT BYRON CENTRAL SCHOOL DISTRICT

A disability can happen to anyone. Long-term disability insurance helps protect your paycheck if you're unable to work for a long period of time after a serious condition, injury or sickness.

To learn more about Long-Term Disability insurance, visit thehartford.com/employeebenefits

COVERAGE INFORMATION

BENEFIT PERCENTAGE (PERCENT OF YOUR EARNINGS)	MAXIMUM	MINIMUM (BASED ON MONTHLY INCOME LOSS BEFORE THE DEDUCTION OF OTHER INCOME BENEFITS)	BENEFIT STARTS (ELIMINATION PERIOD)	BENEFIT DURATION
60%	$6,000	The greater of $100 or 10% of the benefit	After 90 days disabled	Disabled before: Age 63 Benefit duration: As long as you are disabled Benefit duration maximum: The greater of your Social Security Normal Retirement Age or 4 years

PREMIUMS

See the Premium Worksheet.[2]

ASKED & ANSWERED

WHO IS 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.

AM I GUARANTEED COVERAGE?

If you elect coverage during your scheduled enrollment period or if this is the first time you are eligible to elect coverage, evidence of insurability is not required.

Outside your scheduled enrollment period and during a family status change period, evidence of insurability is required to elect coverage for the first time.[2]

This coverage is subject to a pre-existing condition exclusion, which is detailed on the Limitations & Exclusions sheet.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premium is provided on the Premium Worksheet.

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, within 31 days of the date you have a change in family status, or within 1st of month following date of hire days of the completion of any eligibility waiting period established by your employer.

WHEN DOES THIS INSURANCE BEGIN?

Subject to any eligibility waiting period established by your employer, insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect.

WHEN DOES THIS INSURANCE END?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you leave your employer, or the coverage is no longer offered.

WHAT DOES IT MEAN TO BE DISABLED?

Disability is defined in The Hartford's certificate 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 condition covered by the insurance, and as a result, your current monthly earnings are less than 80% of your pre-disability earnings. Once you have been disabled for 2 years following the elimination period, 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 less than or equal to 60% of your pre-disability earnings.

Pre-disability earnings is your regular monthly rate of pay, not counting commissions, bonuses, overtime pay or any other fringe benefit or extra compensation.

[1]U.S. Social Security Administration Fact Sheet. Web. 30 June 2017 https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf
[2]Rates and/or benefits may be changed.
[3]The Long Term Disability policy contains a Pre-Existing Condition Exclusion. Please refer to the certificate for more information on exclusions and limitations, such as Pre-Existing Conditions.

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This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation practices, please review our website http://thehartford.com/group-benefits-producer-compensation. Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

VOLUNTARY GROUP TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENTINSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Approximately 50 million households recognize they need more life insurance (40 percent of households).[1]

PORT BYRON CENTRAL SCHOOL DISTRICT

The group term Life and Accidental Death and Dismemberment (AD&D) insurance available through your employer is a smart, affordable way to purchase the extra protection that you and your family may need. Life and AD&D insurance offers financial protection by providing you coverage in case of an untimely death or an accident that destroys your income-earning ability. Life benefits are disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life and AD&D insurance, visit thehartford.com/employeebenefits

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit[2]: Increments of $20,000 Maximum: the lesser of 1x earnings or $500,000	AD&D: Included
Spouse	Benefit[2]: Increments of $10,000. Maximum: the lesser of 50% of your supplemental coverage or $250,000	AD&D: Included
Child(ren)	Benefit: $10,000	AD&D: Included

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AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT	
Covered accidents or death can occur up to 365 da... 100% of your coverage amount.	
LOSS FROM ACCIDENT	**COVERAGE**
Life	100%
Both Hands or Both Feet or Sight of Both Eyes	100%
One Hand and One Foot	100%
Speech and Hearing in Both Ears	100%
Either Hand or Foot and Sight of One Eye	100%
Movement of Both Upper and Lower Limbs (Quadriplegia)	100%
Movement of Both Lower Limbs (Paraplegia)	75%
Movement of Three Limbs (Triplegia)	75%
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	50%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Movement of One Limb (Uniplegia)	25%
Thumb and Index Finger of Either Hand	25%

[2]Your benefit will be reduced by 35% at age 65, 70 and 75, and 25% at age 80, 85, 90 and 95. Reductions will be applied to the current amount (after all previous reductions).

PREMIUMS

See the Life Premium Worksheet.[3]

ASKED & ANSWERED

WHO IS 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.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 19.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to "spouse" in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

If you enroll during your annual enrollment period or are newly eligible and elect an amount that exceeds the guaranteed issue amount of $200,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you enroll after your annual or initial enrollment period, evidence of insurability will be required for all coverage amounts.

If you enroll during your annual enrollment period or are newly eligible and elect an amount that exceeds the guaranteed issue amount of $30,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you enroll after your annual or initial enrollment period, evidence of insurability will be required for all coverage amounts.

This insurance is guaranteed issue coverage – it is available without having to provide information about your child(ren)'s health.

AD&D is available without having to provide information about your or your family's health.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premiums are provided on the Life Premium Worksheet. You have a choice of coverage amounts. You may elect insurance for you only, or for you and your dependent(s).

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, or within 31 days of the date you have a change in family status.

WHEN DOES THIS INSURANCE BEGIN?

Insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect.

Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

WHEN DOES THIS INSURANCE END?

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this life coverage with you. Coverage may be continued for you and your dependent(s) under an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion are described in the certificate. Conversion is not available for AD&D coverage.

[1]LIMRA, Facts About Life 2016. Web. 30 June 2017. <https://www.limra.com/uploadedFiles/limra.com/LIMRA_Root/Posts/PR/_Media/PDFs/Facts-of-Life-2016.pdf>
[3]Rates and/or benefits may be changed. Rates are based on the age of the insured person and increase on the first of the month following your birthday as you enter each new age category.

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GROUP VOLUNTARY ACCIDENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

PORT BYRON CENTRAL SCHOOL DISTRICT

With Accident insurance, you'll receive payment(s) associated with a covered injury and related services. You can use the payment in any way you choose – from expenses not covered by your major medical plan to day-to-day costs of living such as the mortgage or your utility bills.

More than 3.5 million children ages 14 and younger get hurt annually playing sports or participating in recreational activities.[1]

To learn more about Accident insurance, visit thehartford.com/employeebenefits

COVERAGE INFORMATION

This insurance provides benefits when injuries, medical treatment and/or services occur as the result of a covered accident. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your dependent(s).

PLAN INFORMATION		PLAN 1
Coverage Type		On and off-job (24 hour)
BENEFITS		**PLAN 1**
EMERGENCY, HOSPITAL & TREATMENT CARE		
Accident Follow-Up	Up to 3 visits per accident	$50
Acupuncture/Chiropractic Care/PT	Up to 10 visits each per accident	$25
Ambulance – Air	Once per accident	$600
Ambulance – Ground	Once per accident	$200
Blood/Plasma/Platelets	Once per accident	$150
Child Care	Up to 30 days per accident while insured is confined	$25
Daily Hospital Confinement	Up to 365 days per lifetime	$100
Daily ICU Confinement	Up to 30 days per accident	$300
Diagnostic Exam	Once per accident	$100
Emergency Dental	Once per accident	Up to $150
Emergency Room	Once per accident	$100
Hospital Admission	Once per accident	$500
Initial Physician Office Visit	Once per accident	$50
Lodging	Up to 30 nights per lifetime	$100
Medical Appliance	Once per accident	$50
Rehabilitation Facility	Up to 15 days per lifetime	$50
Transportation	Up to 3 trips per accident	$200
Urgent Care	Once per accident	$50
X-ray	Once per accident	$50
SPECIFIED INJURY & SURGERY		**PLAN 1**
Abdominal/Thoracic Surgery	Once per accident	$1,000
Arthroscopic Surgery	Once per accident	$200
Burn	Once per accident	Up to $5,000
Burn – Skin Graft	Once per accident for third degree burn(s)	25% of burn benefit
Concussion	Up to 3 per year	$100
Dislocation	Once per joint per lifetime	Up to $2,000
Eye Injury	Once per accident	Up to $300
Fracture	Once per bone per accident	Up to $3,000

Hernia Repair	Once per accident	$100
Joint Replacement	Once per accident	$1,500
Knee Cartilage	Once per accident	Up to $500
Laceration	Once per accident	Up to $400
Ruptured Disc	Once per accident	$500
Tendon/Ligament/Rotator Cuff	Up to 2 per accident	Up to $800
CATASTROPHIC		**PLAN 1**
Accidental Death	Within 90 days; Spouse @ 50% and child @ 25%	$20,000
Common Carrier Death	Within 90 days; Spouse @ 50% and child @ 25%	$60,000
Coma	Once per accident	$5,000
Dismemberment	Once per accident	Up to $20,000
Home Health Care	Up to 30 days per accident	$50
Paralysis	Once per accident	Up to $5,000
Prosthesis	Up to 2 per accident	Up to $1,000

PREMIUMS

The amounts shown are semi-monthly amounts (24 payments/deductions per year):[3]

COVERAGE TIER	
Employee Only	**$2.09** ($0.14 per day)
Employee & Spouse/Partner	**$3.30** ($0.22 per day)
Employee & Child(ren)	**$3.49** ($0.23 per day)
Employee & Family	**$5.49** ($0.36 per day)

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible for this insurance if you are an active full-time employee who works at least 30 hours per week on a regularly scheduled basis, and are less than age 80.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 19.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to "spouse" in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your or your family's health. All you have to do is elect the coverage to become insured.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premiums are provided above. You may elect insurance for you only, or for you and your dependent(s), by choosing the applicable coverage tier.

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, or within 31 days of the date you have a change in family status.

WHEN DOES THIS INSURANCE BEGIN?

Insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

WHEN DOES THIS INSURANCE END?

This insurance will end when you or your dependents no longer satisfy the applicable eligibility conditions, or when you reach the age of 80, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this coverage with you. Coverage may be continued for you and your dependent(s) under a group portability policy. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for portability are described in the certificate.

[1]"Sports Injury Statistics." Stanford Children's Health, n.d. Web. 30 June 2017. http://www.stanfordchildrens.org/en/topic/default?id=sports-injury-statistics-90-P02787
[3]Rates and/or benefits may be changed.

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GROUP VOLUNTARY SPECIFIED DISEASE INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

65% of American cancer survivors did not have sufficient income to cover out-of-pocket expenses for cancer treatment and other incurred debts related to the illness.[1]

PORT BYRON CENTRAL SCHOOL DISTRICT

Facing a serious illness can be devastating both emotionally and financially. Major medical insurance may pick up most of the tab, but can still leave out-of-pocket expenses that add up quickly. Specified Disease insurance can provide a lump-sum benefit upon diagnosis that can be used however you choose - from expenses related to treatment, to deductibles or day-to-day costs of living such as the mortgage or your utility bills.

To learn more about Specified Disease insurance, visit thehartford.com/employeebenefits

COVERAGE INFORMATION

Benefit amounts for covered illnesses are based on the coverage amount in effect for you or an insured dependent at the time of diagnosis.

COVERAGE AMOUNT	
Employee Coverage Amount	$10,000 or $20,000
Spouse Coverage Amount	50% of your coverage amount
Child(ren) Coverage Amount	$5,000
COVERED ILLNESSES	**BENEFIT AMOUNTS**
CANCER CONDITIONS	
Invasive Cancer	100% of coverage amount
Non-invasive Cancer Skin Cancer	25% of coverage amount $250
VASCULAR CONDITIONS	
Heart Attack; Stroke	100% of coverage amount
Coronary Artery Bypass Graft	25% of coverage amount
OTHER SPECIFIED CONDITIONS	
End Stage Renal Failure; Major Organ Transplant*;	100% of coverage amount
ADDITIONAL BENEFITS	**BENEFIT AMOUNTS**
Health Screening Benefit	$75 once per year per covered person
FEATURES	**DETAILS**
Coverage Maximum – Primary Insured & Spouse	200% of coverage amount
Coverage Maximum – Child(ren)	100% of coverage amount

PREMIUMS

See the Premium Worksheet.[3]

SKED & ANSWERED

WHO IS ELIGIBLE?
You are eligible for this insurance if you are an active full-time employee who works at least 30 hours per week on a regularly scheduled basis, and are less than age 80.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 19.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?
Yes. Any reference to "spouse" in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?
This insurance is guaranteed issue coverage – it is available without having to provide information about your or your family's health. All you have to do is elect the coverage to become insured.[4]

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?
Premiums are provided on the Premium Worksheet. You have a choice of coverage amounts. You may elect insurance for you only, or for you and your dependent(s), by choosing the applicable coverage tier.

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?
You may enroll during any scheduled enrollment period, or within 31 days of the date you have a change in family status.

WHEN DOES THIS INSURANCE BEGIN?
Insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

WHEN DOES THIS INSURANCE END?
This insurance will end when you (or your dependents) no longer satisfy the applicable eligibility conditions, or when you reach the age of 80, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

[1]Insights From Survivors: Managing the Personal, Emotional and Financial Impact of Cancer, Washington National Institute for Wellness Solutions, 2014.
[3]Rates and/or benefits may be changed. Rates are based on the age of the insured person and increase on the first of the month following your birthday as you enter each new age category.
[4]The Specified Disease policy is guaranteed issue, but does contain a Pre-Existing Condition Limitation. Please refer to the certificate for more information on exclusions and limitations, such as Pre-Existing Conditions.

LIMITATIONS & EXCLUSIONS

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This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your benefit will be reduced by 35% at age 65, 70 and 75, and 25% at age 80, 85, 90 and 95. Reductions will be applied to the current amount (after all previous reductions).
- A supplemental or voluntary life benefit will not be paid if death occurs by suicide within two years (or as allowed by state law) of purchasing this coverage.
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Coverage may not be elected for a dependent who is in active full-time military service.
- Child(ren) may only be covered as a dependent of one employee.
- Infants may receive a reduced benefit prior to the age of six months.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your benefit will be reduced by 35% at age 65, 70 and 75, and 25% at age 80, 85, 90 and 95. Reductions will be applied to the current amount (after all previous reductions).
- This insurance does not cover losses caused by:
  - Sickness; disease; or any treatment for either
  - Any infection, except certain ones caused by an accidental cut or wound
  - Intentionally self-inflicted injury, suicide or suicide attempt
  - War or act of war, whether declared or not
  - Injury sustained while in the armed forces of any country or international authority
  - Injury sustained on aircraft in certain circumstances
  - Taking prescription or illegal drugs unless prescribed by or administered by a licensed physician
  - Injury sustained while riding, driving, or testing any motor vehicle for racing
  - Injury sustained while committing or attempting to commit a felony
  - Injury sustained while driving while intoxicated
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Child(ren) may only be covered as a dependent of one employee.

DEFINITIONS

- Loss means, with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to sight, speech or hearing, entire and irrecoverable loss thereof; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints; with regard to movement, complete and irreversible paralysis of such limbs.
- Injury means bodily injury resulting directly from an accident, independent of all other causes, which occurs while you or your dependent(s) have coverage.

GROUP LONG TERM DISABILITY INSURANCE

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS

- You must be under the regular care of a physician to receive benefits.
- You cannot receive 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
  - Your being engaged in an illegal occupation

PRE-EXISTING CONDITIONS

- Your insurance excludes 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 certificate, you will be covered for a disability due to that condition only if:
  - You have not received treatment for your condition for 3 months before the effective date of your insurance, or
  - You have been insured under this coverage for 12 months 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

LIMITATIONS

- **Mental Illness Limitation.** If you are disabled because of Mental Illness, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.
- **Substance Abuse Limitation.** If you are disabled because of alcoholism or use of narcotics, sedatives, stimulants, hallucinogens or other similar substance, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.

OFFSETS

- 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 cost-of-living increases

This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the Policy:

Insured's monthly [Pre-Disability Earnings/Basic Monthly Pay] $3,000
Long term disability benefits percentage x 60%
Unreduced maximum benefit $1,800
Less Social Security disability benefit per month - $900
Less state disability income benefit per month - $300
Total amount of long term disability benefit per month $600

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

GROUP ACCIDENT INSURANCE

LIMITATIONS AND EXCLUSIONS
The benefits payable are based on the insurance in effect on the date of the covered accident, subject to the definitions, limitations, exclusions and other provisions of the policy.

You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

This insurance does not provide benefits for any loss that results from or is caused by:
- Suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted injury
- War or act of war, whether declared or undeclared, or a nuclear, chemical, biological, or radiological event
- A covered person's participation in a felony, riot or insurrection
- A covered person's service in the armed forces or units auxiliary to it
- A covered person's taking drugs, unless as prescribed by or administered by a physician, or being intoxicated as defined by the jurisdiction in which the cause of loss was incurred
- A covered person's sickness or bacterial infection
- A covered person's participation in bungee jumping or hang gliding
- A covered person's participation or competition in semi-professional or professional sports
- Cosmetic surgery or any other elective procedure that is not medically necessary
- While a covered person is on any aircraft: as a pilot, crewmember or student pilot; as a flight instructor or examiner; if it is owned, operated or leased by or on behalf of the policyholder, or any employer or organization whose eligible persons are covered under the policy; or being used for tests, experimental purposes, stunt flying,racing or endurance tests
- Operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test

All exclusions may not be applicable, or may be adjusted, as required by state regulations in the situs state of a group.

NOTICES

THIS IS A LIMITED ACCIDENT ONLY BENEFIT POLICY

IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.

For New York Residents:
This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.
IMPORTANT NOTICE — THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

GROUP SPECIFIED DISEASE INSURANCE

LIMITATIONS AND EXCLUSIONS
The benefits payable are based on the insurance in effect on the date of the diagnosis of a covered illness, subject to the definitions, limitations, exclusions and other provisions of the policy.

You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

Benefit Separation Periods. If a covered person is diagnosed with a covered illness, and is subsequently diagnosed with another covered illness, the following separation periods apply between benefit payments. If the subsequent diagnosis is for: 1) A different, non-related covered illness than the first diagnosis (e.g. a cancer illness then a vascular illness), then no separation period applies; 2) A covered illness that is related to the first (e.g. two vascular illnesses, like heart attack and stroke), then a 0 separation period applies; 3) The same covered illness as the first (e.g. two heart attacks) as allowed by the Recurrence Benefit, then a 0 separation period applies.

Pre-Existing Condition Limitation. We will not pay a benefit or any increase in benefits for any Specified Disease for a pre-existing condition, unless at the time of a positive diagnosis a covered person has been continuously insured under the policy or any prior group plan for months. Pre-existing condition, as used in this limitation, means any Specified Disease for which medical care is received within the month period prior to the effective date of insurance for a covered person or prior to the effective date of any increase in coverage for a covered person, under the policy or any prior group plan.

Exclusions. This insurance does not provide benefits for any loss that results from or is caused by:
- Suicide, attempted suicide or intentionally self-inflicted injury, whether sane or insane
- War or act of war, declared or undeclared
- A covered person's participation in a felony, riot or insurrection
- A covered person's engaging in any illegal occupation
- A covered person's service in the armed forces or units auxiliary to them

General Limitations. Benefits under the policy are not payable for any covered illness:
- Diagnosed prior to the effective date of insurance for a covered person (except for newborn children)
- Diagnosed during an applicable benefit separation period
- For which a covered person has already received a benefit payment under the policy, unless the covered illness is included in a recurrence provision
- For which a covered person has already received a benefit payment under the recurrence provision

In addition, benefits are not payable for any critical illness not included as a covered illness in your certificate.

NOTICES

THIS POLICY PROVIDES LIMITED BENEFITS FOR SPECIFIED DISEASES ONLY.

This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage. In NY: This policy provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

Please note: For residents of CA, GA, NJ and NY, since this is a limited benefit health product, persons without comprehensive health benefits from an individual or group health insurance policy or an HMO, or an employer plan providing essential health benefits are not eligible for this insurance. In addition, NY residents covered by another Critical Illness or specified disease plan are not eligible for coverage. For residents of CT, ID, ME, NH, and WV, a person covered by any Title XIX program (Medicaid or any similar name) is not eligible for this insurance.

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT.

This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.

Premium Worksheet

THE HARTFORD

Rates and/or benefits can change. Rates are based on the employee's age and increase as you enter each new age category.

VOLUNTARY LONG TERM DISABILITY INSURANCE

Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rates	$0.0275	$0.0350	$0.0635	$0.1100	$0.1650	$0.2480	$0.3215	$0.3090	$0.3210	$0.2255	$0.2255	$0.2255

To calculate your semi-monthly premium amount, use the following formula.

_____	÷ 12 =	_____	÷ 100 =	_____	x	_____	= _____
Your Annual Earnings Maximum = $120,000		Your Monthly Earnings				Rate	Premium Amount

VOLUNTARY SPECIFIED DISEASE INSURANCE

Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)

NON-TOBACCO USER

Benefit Amount	Age	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
$10,000	Employee Only	$1.19	$1.50	$1.73	$2.13	$2.79	$3.91	$5.18	$6.84	$9.35	$12.73	$17.87	$24.05
	Employee & Spouse/Partner	$2.06	$2.55	$2.90	$3.49	$4.52	$6.26	$8.21	$10.78	$14.65	$19.85	$27.74	$24.05
	Employee & Child(ren)	$2.08	$2.36	$2.53	$2.90	$3.54	$4.65	$5.90	$7.56	$10.07	$13.45	$18.59	$24.77
	Employee & Family	$3.10	$3.55	$3.84	$4.39	$5.39	$7.11	$9.05	$11.63	$15.49	$20.69	$28.58	$37.91
$20,000	Employee Only	$1.72	$2.30	$2.73	$3.51	$4.79	$6.96	$9.46	$12.75	$17.72	$24.42	$34.65	$46.97
	Employee & Spouse/Partner	$2.85	$3.72	$4.38	$5.54	$7.48	$10.82	$14.67	$19.75	$27.40	$37.70	$53.40	$72.01
	Employee & Child(ren)	$2.62	$3.16	$3.53	$4.28	$5.53	$7.70	$10.19	$13.47	$18.44	$25.14	$35.37	$47.69
	Employee & Family	$3.89	$4.73	$5.31	$6.43	$8.35	$11.68	$15.52	$20.60	$28.24	$38.54	$54.24	$72.85

VOLUNTARY SPECIFIED DISEASE INSURANCE

Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)

TOBACCO USER

Benefit Amount	Age	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
$10,000	Employee Only	$1.23	$1.61	$1.94	$2.57	$3.66	$5.72	$8.38	$12.10	$17.90	$26.05	$35.65	$43.28
	Employee & Spouse/Partner	$2.13	$2.71	$3.24	$4.19	$5.89	$9.09	$13.19	$18.93	$27.84	$40.38	$55.26	$66.93
	Employee & Child(ren)	$2.12	$2.47	$2.75	$3.34	$4.40	$6.46	$9.11	$12.82	$18.62	$26.77	$36.37	$44.00
	Employee & Family	$3.17	$3.71	$4.17	$5.09	$6.75	$9.95	$14.04	$19.77	$28.68	$41.22	$56.11	$67.78

$20,000	Employee Only	$1.81	$2.51	$3.16	$4.39	$6.53	$10.59	$15.88	$23.26	$34.82	$51.06	$70.20	$85.43
	Employee & Spouse/Partner	$2.98	$4.05	$5.05	$6.92	$10.21	$16.50	$24.63	$36.04	$53.79	$78.76	$108.46	$131.74
	Employee & Child(ren)	$2.70	$3.37	$3.96	$5.16	$7.27	$11.32	$16.60	$23.99	$35.54	$51.78	$70.92	$86.15
	Employee & Family	$4.02	$5.05	$5.99	$7.82	$11.08	$17.35	$25.48	$36.88	$54.63	$79.60	$109.30	$132.58

VOLUNTARY ACCIDENT INSURANCE

Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)

COVERAGE TIER	PLAN 1
Employee Only	**$2.09** ($0.14 per day)
Employee & Spouse/Partner	**$3.30** ($0.22 per day)
Employee & Child(ren)	**$3.49** ($0.23 per day)
Employee & Family	**$5.49** ($0.36 per day)

VOLUNTARY TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)

Benefit	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$20,000	$0.71	$0.62	$0.73	$1.02	$1.43	$2.23	$3.33	$4.61	$5.53	$7.91	$10.08	$28.90
$40,000	$1.42	$1.24	$1.46	$2.04	$2.86	$4.46	$6.66	$9.22	$11.06	$15.82	$20.16	$57.80
$60,000	$2.13	$1.86	$2.19	$3.06	$4.29	$6.69	$9.99	$13.83	$16.59	$23.73	$30.24	$86.70
$80,000	$2.84	$2.48	$2.92	$4.08	$5.72	$8.92	$13.32	$18.44	$22.12	$31.64	$40.32	$115.60
$100,000	$3.55	$3.10	$3.65	$5.10	$7.15	$11.15	$16.65	$23.05	$27.65	$39.55	$50.40	$144.50
$120,000	$4.26	$3.72	$4.38	$6.12	$8.58	$13.38	$19.98	$27.66	$33.18	$47.46	$60.48	$173.40
$140,000	$4.97	$4.34	$5.11	$7.14	$10.01	$15.61	$23.31	$32.27	$38.71	$55.37	$70.56	$202.30
$160,000	$5.68	$4.96	$5.84	$8.16	$11.44	$17.84	$26.64	$36.88	$44.24	$63.28	$80.64	$231.20
$180,000	$6.39	$5.58	$6.57	$9.18	$12.87	$20.07	$29.97	$41.49	$49.77	$71.19	$90.72	$260.10
$200,000	$7.10	$6.20	$7.30	$10.20	$14.30	$22.30	$33.30	$46.10	$55.30	$79.10	$100.80	$289.00
$220,000	$7.81	$6.82	$8.03	$11.22	$15.73	$24.53	$36.63	$50.71	$60.83	$87.01	$110.88	$317.90
$240,000	$8.52	$7.44	$8.76	$12.24	$17.16	$26.76	$39.96	$55.32	$66.36	$94.92	$120.96	$346.80
$260,000	$9.23	$8.06	$9.49	$13.26	$18.59	$28.99	$43.29	$59.93	$71.89	$102.83	$131.04	$375.70
$280,000	$9.94	$8.68	$10.22	$14.28	$20.02	$31.22	$46.62	$64.54	$77.42	$110.74	$141.12	$404.60
$300,000	$10.65	$9.30	$10.95	$15.30	$21.45	$33.45	$49.95	$69.15	$82.95	$118.65	$151.20	$433.50
$320,000	$11.36	$9.92	$11.68	$16.32	$22.88	$35.68	$53.28	$73.76	$88.48	$126.56	$161.28	$462.40
$340,000	$12.07	$10.54	$12.41	$17.34	$24.31	$37.91	$56.61	$78.37	$94.01	$134.47	$171.36	$491.30
$360,000	$12.78	$11.16	$13.14	$18.36	$25.74	$40.14	$59.94	$82.98	$99.54	$142.38	$181.44	$520.20
$380,000	$13.49	$11.78	$13.87	$19.38	$27.17	$42.37	$63.27	$87.59	$105.07	$150.29	$191.52	$549.10
$400,000	$14.20	$12.40	$14.60	$20.40	$28.60	$44.60	$66.60	$92.20	$110.60	$158.20	$201.60	$578.00
$420,000	$14.91	$13.02	$15.33	$21.42	$30.03	$46.83	$69.93	$96.81	$116.13	$166.11	$211.68	$606.90
$440,000	$15.62	$13.64	$16.06	$22.44	$31.46	$49.06	$73.26	$101.42	$121.66	$174.02	$221.76	$635.80
$460,000	$16.33	$14.26	$16.79	$23.46	$32.89	$51.29	$76.59	$106.03	$127.19	$181.93	$231.84	$664.70
$480,000	$17.04	$14.88	$17.52	$24.48	$34.32	$53.52	$79.92	$110.64	$132.72	$189.84	$241.92	$693.60
$500,000	$17.75	$15.50	$18.25	$25.50	$35.75	$55.75	$83.25	$115.25	$138.25	$197.75	$252.00	$722.50

SPOUSE/PARTNER VOLUNTARY TERM LIFE LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$2.89	$0.33	$0.39	$0.54	$0.76	$1.18	$1.77	$2.45	$2.93	$4.19	$5.04	$1.53
$20,000	$5.78	$0.65	$0.77	$1.07	$1.51	$2.35	$3.53	$4.89	$5.85	$8.38	$10.08	$3.05
$30,000	$8.67	$0.98	$1.16	$1.61	$2.27	$3.53	$5.30	$7.34	$8.78	$12.57	$15.12	$4.58
$40,000	$11.56	$1.30	$1.54	$2.14	$3.02	$4.70	$7.06	$9.78	$11.70	$16.76	$20.16	$6.10
$50,000	$14.45	$1.63	$1.93	$2.68	$3.78	$5.88	$8.83	$12.23	$14.63	$20.95	$25.20	$7.63
$60,000	$17.34	$1.95	$2.31	$3.21	$4.53	$7.05	$10.59	$14.67	$17.55	$25.14	$30.24	$9.16
$70,000	$20.23	$2.28	$2.70	$3.75	$5.29	$8.23	$12.36	$17.12	$20.48	$29.33	$35.28	$10.68

$80,000	$23.12	$2.60	$3.08	$4.28	$6.04	$9.40	$14.12	$19.56	$23.40	$33.52	$40.32	$12.21
$90,000	$26.01	$2.93	$3.47	$4.82	$6.80	$10.58	$15.89	$22.01	$26.33	$37.71	$45.36	$13.73
$100,000	$28.90	$3.25	$3.85	$5.35	$7.55	$11.75	$17.65	$24.45	$29.25	$41.90	$50.40	$15.26
$110,000	$31.79	$3.58	$4.24	$5.89	$8.31	$12.93	$19.42	$26.90	$32.18	$46.09	$55.44	$16.79
$120,000	$34.68	$3.90	$4.62	$6.42	$9.06	$14.10	$21.18	$29.34	$35.10	$50.28	$60.48	$18.31
$130,000	$37.57	$4.23	$5.01	$6.96	$9.82	$15.28	$22.95	$31.79	$38.03	$54.47	$65.52	$19.84
$140,000	$40.46	$4.55	$5.39	$7.49	$10.57	$16.45	$24.71	$34.23	$40.95	$58.66	$70.56	$21.36
$150,000	$43.35	$4.88	$5.78	$8.03	$11.33	$17.63	$26.48	$36.68	$43.88	$62.85	$75.60	$22.89
$160,000	$46.24	$5.20	$6.16	$8.56	$12.08	$18.80	$28.24	$39.12	$46.80	$67.04	$80.64	$24.42
$170,000	$49.13	$5.53	$6.55	$9.10	$12.84	$19.98	$30.01	$41.57	$49.73	$71.23	$85.68	$25.94
$180,000	$52.02	$5.85	$6.93	$9.63	$13.59	$21.15	$31.77	$44.01	$52.65	$75.42	$90.72	$27.47
$190,000	$54.91	$6.18	$7.32	$10.17	$14.35	$22.33	$33.54	$46.46	$55.58	$79.61	$95.76	$28.99
$200,000	$57.80	$6.50	$7.70	$10.70	$15.10	$23.50	$35.30	$48.90	$58.50	$83.80	$100.80	$30.52
$210,000	$60.69	$6.83	$8.09	$11.24	$15.86	$24.68	$37.07	$51.35	$61.43	$87.99	$105.84	$32.05
$220,000	$63.58	$7.15	$8.47	$11.77	$16.61	$25.85	$38.83	$53.79	$64.35	$92.18	$110.88	$33.57
$230,000	$66.47	$7.48	$8.86	$12.31	$17.37	$27.03	$40.60	$56.24	$67.28	$96.37	$115.92	$35.10
$240,000	$69.36	$7.80	$9.24	$12.84	$18.12	$28.20	$42.36	$58.68	$70.20	$100.56	$120.96	$36.62
$250,000	$72.25	$8.13	$9.63	$13.38	$18.88	$29.38	$44.13	$61.13	$73.13	$104.75	$126.00	$38.15

CHILD(REN) VOLUNTARY TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)

Benefit Amount	Cost For Each Child	x	Number of Covered Children	=	Cost For All Children
$10,000	$0.30	x		=	

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT.

This document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Benefits are subject to state availability. Policy terms and conditions vary by state. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.

ADDITIONAL SERVICES

PORT BYRON CENTRAL SCHOOL DISTRICT

If you are enrolled in insurance coverage with The Hartford, you may also be eligible to receive additional services at no cost to you. These services help with challenges that come before and after a claim. Be sure to read the information provided below; The Hartford wants to be there when you need us.

SERVICES AVAILABLE

COVERAGE ENROLLED IN	ADDITIONAL SERVICES AVAILABLE
Disability	Ability Assist Counseling Services Health Champion

ASKED & ANSWERED

WHAT IS ABILITY ASSIST COUNSELING SERVICES?

Ability Assist®[4] Counseling Services provides access to Master's- and PhD-degreed clinicians for 24/7 assistance if you're enrolled in our long term disability plan. This includes 3 face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

WHAT IS HEALTHCHAMPION?

HealthChampion[SM5] offers unlimited access to benefit specialists and nurses for administrative and clinical support to address medical care and health insurance claims concerns if you're enrolled in our long term disability plan. Service includes: guidance on health insurance claims and billing support, explanation of benefits, cost estimates and fee negotiation, information related to conditions and available treatments, and support to help prepare for medical visits.

[4] Ability Assist® is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.
[5] HealthChampion[SM] is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.

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Benefits Enrollment Form for PORT BYRON CENTRAL SCHOOL DISTRICT

Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 1 (800) 523-2233
(A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Instructions: 1) Please print clearly with blue or black ink and provide complete information. (Missing information causes delays.) **2)** Please review the applicable benefit highlight/summary information for each product prior to electing coverage. You (employee) and your dependent(s) (if applicable) are only eligible for coverage as allowed by the applicable group policy. **3)** For each coverage, please check the appropriate box(es) to elect or decline coverage and enter amounts where necessary. **4)** Please sign and date the form. **5)** Submit the form as instructed by your benefits administrator by the enrollment deadline. (Do not submit or send the form directly to The Hartford.)

EMPLOYEE INFORMATION

Name (FIRST MI LAST)	**Employee Social Security Number**	**Date of Birth** (MM/DD/YYYY)
Date of Hire (MM/DD/YYYY)		

TOBACCO USE INFORMATION (IF YOU DO NOT COMPLETE THIS SECTION, TOBACCO PREMIUMS WILL APPLY TO APPLICABLE COVERAGE(S))

Have you (employee) used tobacco or nicotine replacement in any form in the past 12 months? ☐ Yes ☐ No

DEPENDENT INFORMATION (ADDITIONAL CHILDREN MAY BE LISTED ON SEPARATE PAPER AND ATTACHED TO/SUBMITTED WITH THIS FORM)

Spouse/Domestic Partner Name (FIRST MI LAST) ☐ N/A	**Date of Birth**	**Gender** ☐ M ☐ F	**Date Married/Partnered**

Child Name (FIRST MI LAST)	**Date of Birth**	**Gender**	**Child Name** (FIRST MI LAST)	**Date of Birth**	**Gender**
		☐ M ☐ F			☐ M ☐ F
		☐ M ☐ F			☐ M ☐ F

VOLUNTARY LONG TERM DISABILITY INSURANCE

Coverage for Employee Only	**Benefit Amount**	**Semi-monthly Premium Amount** (Cost per Pay Period – 24/Year)	**Elect Coverage or Continue Current**	**Decline Coverage**
Employee	60% of earnings, up to $6,000 each month	$_____ (Requires EOI*)	☐	☐

Additional Information:

- Your benefit amount is based on your earnings; therefore, your benefit and premium amount will change as your earnings change.
- Your premium amount is based on your age; therefore, your premium amount will change, as you grow older.
- *If you were previously eligible for coverage and are enrolling for the first time, you must complete and submit an evidence of insurability (EOI) form/health application. The form is available from your employer.
- A claim for benefits may not be approved for a pre-existing condition, as stated in the applicable policy.

IMPORTANT SPECIFIED DISEASE INSURANCE ELIGIBILITY INFORMATION

The following notice(s) apply to all Specified Disease and Voluntary Specified Disease coverage presented on this form:

- Any resident of CA, GA, or NJ (you or your dependent(s)) that does not have major medical insurance (or an equivalent) is not eligible for and should not enroll for critical illness coverage.
- Any resident of CT, ID, ME, NH or WV (you or your dependent(s)) that participates in any Title XIX program (e.g. Medicaid or any similar name) is not eligible for and should not enroll for critical illness coverage.
- Any resident of NY (you or your dependent(s)) that does not have major medical insurance (or an equivalent) is not eligible for and should not enroll for critical illness or specified disease coverage.
- Any resident of NY (you or your dependent(s)) that has coverage under any other specified disease policy is not eligible for and should not enroll for this specified disease coverage, unless the existing coverage is to be replaced in full by this coverage.
- SPECIFIED DISEASE INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

VOLUNTARY SPECIFIED DISEASE INSURANCE

Employee Benefit Amount – Select One Option		Coverage Tier – Select One Option	Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)			
			$10,000		$20,000	
			Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
☐ $10,000	☐ $20,000	☐ Employee Only	$_____	$_____	$_____	$_____
		☐ Employee & Spouse/Partner	$_____	$_____	$_____	$_____
		☐ Employee & Child(ren)	$_____	$_____	$_____	$_____
		☐ Employee & Family	$_____	$_____	$_____	$_____
☐ Decline Coverage		N/A	N/A			

Additional Information:

- Your premium amount is based on your age; therefore, your premium amount will change as you grow older.
- The benefit amount(s) available under this plan is/are subject to a reduction schedule beginning at age 70.
- The benefits under this policy terminate when you reach age 80.

IMPORTANT ACCIDENT INSURANCE ELIGIBILITY INFORMATION

The following notice(s) apply to all Accident and Voluntary Accident coverage presented on this form:

- ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Coverage for Employee & Dependent(s)	Coverage Tier – Select One Option	Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)
PLAN 1 – 24 hour coverage (On and off-job)	☐ Employee Only	$2.09
	☐ Employee & Spouse/Partner	$3.30
	☐ Employee & Child(ren)	$3.49
	☐ Employee & Family	$5.49
	☐ Decline Coverage	N/A

VOLUNTARY TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

You must enroll for this coverage in order for your dependents to be eligible for this coverage.

Coverage for Employee Only	Benefit Amount – Select One Option	Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)
Employee	☐ $20,000	$_____
	☐ $40,000	$_____
	☐ $200,000	$_____
	☐ $500,000 (Requires EOI*)	$_____
	☐ $_____	$_____
	☐ Decline Employee Coverage	N/A
Spouse/Partner	☐ $10,000	$_____
	☐ $20,000	$_____
	☐ $30,000	$_____
	☐ $250,000 (Requires EOI*)	$_____
	☐ $_____	$_____
	☐ Decline Spouse/Partner Coverage	N/A
Child(ren) • The premium amount(s) shown apply to each child	☐ $10,000	$0.30 for each child
	☐ Decline Child(ren) Coverage	N/A

Additional Information:

- *If you enroll during your annual enrollment period or are newly eligible and elect an amount that exceeds the guaranteed issue amount of $30,000, your spouse/partner will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you enroll after your annual or initial enrollment period, evidence of insurability will be required for all coverage amounts.
- The premium amount(s) for you and your spouse/partner are based on your (employee) age; therefore, the premium amount(s) will change as you grow older.
- The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 65.
- The child benefit amount listed applies to any child age 6 months or older. A different amount may apply to any child under the age of 6 months.
- To determine the premium amount for all child(ren), multiply the premium amount by the number of eligible children you have.

BENEFICIARY DESIGNATION (PLEASE ENSURE YOUR BENEFICIARY DESIGNATION IS CLEAR SO THERE IS NO QUESTION OF YOUR INTENT)

This designation is for **all** group insurance coverage issued by The Hartford for which benefits are payable to a beneficiary or survivor (as indicated by each specific policy) in the event of your death, unless otherwise requested by you in writing. This designation may be changed upon written request. **All** information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless percentages are stated below. The **percentages must total 100%** for all Primary Beneficiaries and 100% for all Contingent Beneficiaries. If you need to designate more beneficiaries than space will allow, please include the additional information on a separate paper and attach it to/submit it with this form, clearly stating your name. Please consult your benefits administrator or legal advisor for assistance or additional information.

Primary Beneficiary(ies) (PRIMARY BENEFICIARIES ARE FIRST IN LINE TO RECEIVE BENEFITS IF LIVING AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

Contingent Beneficiary(ies) (CONTINGENT(S) WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS ALIVE AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

CONFIRMATION & SIGNATURE

By signing below:

- I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.
- I understand and agree that: 1) 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; 2) My request for coverage may be denied by The Hartford; 3) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) Only the insurance policy(ies) issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy; 6) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 7) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.
- I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy, and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.
- I have read and understand the "Important Notice – Fraud Warning Statements" that applies to my state of residence.

Employee Signature	**Date of Signature**

END OF FORM – PLEASE REVIEW THE "IMPORTANT NOTICE – FRAUD WARNING STATEMENTS" ON THE FOLLOWING PAGE

Benefits Enrollment Form
Important Notice – Fraud Warning Statements
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

THE HARTFORD

Please read the statement that applies to your state of residence prior to signing the enrollment form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, 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 is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: The falsity of any statement in the application for any policy covered by this chapter 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 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 knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For residents of New Mexico and North Carolina: 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 is guilty of a crime and may be submit to civil fines and criminal penalties.

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.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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 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 by 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.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.