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

(A stock insurance company)

Cultural Group Benefits
Insurance Programs

Enrollment Form Group Term Life Insurance Plan

THE HARTFORD

Policyholder Name: Cultural Group Insurance Trust (CGIT)	**Group Billing #:**	**Group Policy #:**
Participating Organization of:		
MEMBER: First Name **MI** (Optional) **Last Name**		**Date of Birth** (MM/DD/YYYY)
Street (No PO Boxes) **Apt#** (If Applicable)	**City** **State** **Zip**	**Social Security #**
Primary Phone	**Secondary Phone** (Optional)	**Gender** Male ☐ Female ☐
Email		

MEMBER:

Proposed Insured Age	First Year Benefit Amount*	Maximum Graded Benefit Amount*
Under Age 65	**$10,000**	**$20,000**
Age 65-69	**$5,000**	**$10,000**
Age 70+	**$1,000**	**$2,000**

*At age 65, your benefit amount will reduce to 50% of the basic amount. At age 70, your benefit amount will reduce to 10% of the basic amount.

DEPENDENT INFORMATION (If more than 5 children, attach additional sheet.)

Child Name	Gender	Date of Birth	Social Secuity #

CHILDREN COVERAGE: (Optional)

I wish to enroll in coverage for my children:

☐ Yes ☐ No

Children Coverage Amount (choose one):

☐ $5,000* ☐ $7,500*

*The benefit amount is determined by your participating Cultural Association.

If you need assistance, contact the Main Office at 651.287.3278.

BENEFICIARY DESIGNATION

You must select your beneficiary - the person (or more than one person) or legal entitiy (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary - who would receive your benefit if your primary beneficiary dies first.

Please make sure your beenficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your beenfit to be paid to each beneficiary. Please provide all of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your administrator or your own legal advisor.

A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time you die.

Primary Beneficiary(s)

Primary Beneficiary Name	Social Security #	Date of Birth	Relationship	Percentage
Address:			Phone #	
Primary Beneficiary Name	Social Security #	Date of Birth	Relationship	Percentage
Address:			Phone #	

Contingent Beneficiary(s)

Contingent Beneficiary Name	Social Security #	Date of Birth	Relationship	Percentage
Address:			Phone #	
Contingent Beneficiary Name	Social Security #	Date of Birth	Relationship	Percentage
Address:			Phone #	

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for member's insurance may be changed upon written request.

EXISTING LIFE INSURANCE POLICY

By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance?

☐ Yes ☐ No

CONFIRMATION

The opportunity to enroll in the Life and Accident Insurance Company Group Term Life Insurance Plan (AGL-1942). I certify that the above statements are full, complete, and true for each person to be insured, to the best of my/our knowledge.

I understand and agree this insurance will go into effect upon receipt of my first premium payment and this form 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 [Association] can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

Member Signature (Required to activate coverage)	**Date** (MM/DD/YYYY)

FRAUD NOTICE(S)

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 Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false informa-tion in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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 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.

For Residents of Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files 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 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.