



HARTFORD LIFE INSURANCE COMPANY
ENROLLMENT FORM FOR PORTABILITY OF YOUR GROUP LIFE INSURANCE
BENEFITS

-FOR USE IN ALL STATES EXCEPT NEW YORK -

EMPLOYER INSTRUCTIONS:

Employer: Complete Part A of the enrollment form, make a copy for your records and then give this enrollment form to the employee or employee's dependents whose coverage is terminating on or before the date of group coverage termination. If you have any questions please call **1-877-320-0484**.

Important Note: The employee must submit the completed enrollment form and first quarterly premium to the address listed below **within 31 days from the date of group coverage termination or 15 days from the employers signature date on this form whichever is later, but never beyond 91 days from the date of group coverage termination.**

Hartford Life Insurance Company
 Attention: Portability Administration
 P.O. Box 248108
 Cleveland, OH 44124-8108

Part A (must be completed by Employer)

Policyholder Name Board of Supervisors of LSU and Agricultural and Mechanical College	Group Policy Number 395208
Campus Code	

Check coverage(s) to which portability is available:

- | | |
|---|--|
| <input type="checkbox"/> Basic Employee Life | <input type="checkbox"/> Basic Dependent Life |
| <input type="checkbox"/> Supplemental Employee Life | <input type="checkbox"/> Supplemental Dependent Life |

Coverage is terminating for:

Name	Gender	Employee, Spouse or Child	Amount of In Force Basic Life Insurance (If portable)	Portability Cost per \$1,000	Amount of In Force Supplemental Life Insurance (If portable)	Portability Cost per \$1,000
	<input type="checkbox"/> M <input type="checkbox"/> F		\$	\$	\$	\$
	<input type="checkbox"/> M <input type="checkbox"/> F		\$	\$	\$	\$
	<input type="checkbox"/> M <input type="checkbox"/> F		\$	\$	\$	\$
	<input type="checkbox"/> M <input type="checkbox"/> F		\$	\$	\$	\$
	<input type="checkbox"/> M <input type="checkbox"/> F		\$	\$		\$

Reason for coverage termination

- | | | |
|--|---|---|
| <input type="checkbox"/> Termination of Employment | <input type="checkbox"/> Employee/dependent(s) no longer in an eligible class | <input type="checkbox"/> A part time employee |
| <input type="checkbox"/> End of Illness & Injury continuation | <input type="checkbox"/> Surviving or Divorced spouse | <input type="checkbox"/> Layoff |
| <input type="checkbox"/> Other reason (May not be eligible to continue coverage) | Other Reason Explanation: | |

Date Last Actively Worked as a Full time Employee : Employee Coverage Termination Date: Employee ID Number:

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If coverage was extended beyond the date last work please provide the reason for the extension. (Please include any necessary documentation)

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Employee's Job Title: Division or Location Employee Worked at: (If applicable)

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Date of Hire: Base Annual Earnings: How are Wages Paid? Employee's Union Status:

	\$	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary	<input type="checkbox"/> Union <input type="checkbox"/> Non Union
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Note: A person is not eligible to continue group life insurance if he has reached his Defined Retirement Age under the 1983 amendments to the United States Social Security Act. Defined Retirement Ages under the 1983 amendments are as follows:

<u>Year employee becomes 62</u>	<u>Defined Retirement Age</u>	<u>Year employee becomes 62</u>	<u>Defined Retirement Age</u>
thru 1999	65	2017	66 + 2 months
2000	65 + 2 months	2018	66 + 4 months
2001	65 + 4 months	2019	66 + 6 months
2002	65 + 6 months	2020	66 + 8 months
2003	65 + 8 months	2021	66 + 10 months
2004	65 + 10 months	2022 +	67
2005-2016	66		

I understand that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

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

Note: If the Accelerated Death Benefit was included in the terminating employee's policy with the group policyholder it will also be included in the employee's portability policy

Policyholder/Administrator Signature Policyholder/Administrator Name Printed Date

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Title Telephone Number Fax Number

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Email Address

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APPLICANT INSTRUCTIONS:

Applicant: Complete Part B of the enrollment form and make a copy for your records.

Each person electing to continue coverage must elect to continue either 100%, 75% or 50% of the amount of insurance for which they were insured for under the employer's plan as shown in PART A, rounded to the next higher \$1,000 if not already a multiple thereof. In no event may an employee continue an amount of life insurance in excess of \$250,000, or a spouse's continued amount of life insurance exceed \$50,000, or a child's continued amount of life insurance exceed \$10,000. No person's continued amount of life insurance may be less than \$5,000 unless a dependent child.

In order for a dependent child to continue coverage, the former full time employee or employee's dependent spouse must elect to continue their coverage also.

First quarterly premium must be remitted with this enrollment form. The first quarterly premium required for each eligible person to continue 100% of their in-force coverage is shown in Part A. If 75% or 50% of insurance is desired, the premium should be prorated accordingly by multiplying by .75 or .5 respectively. Please make your check or money order payable to "Hartford Life Insurance Company". Do not send cash.

Important Note: The completed enrollment form and first quarterly premium must be submitted to the address listed below within 31 days from the date of group coverage termination or 15 days from the employers signature date on this form whichever is later, but never beyond 91 days from the date of group coverage termination.

Should your prior employer provide you with the Portability Enrollment form late, your right to **enroll** for coverage does not extend beyond 91 days after the **Date of Group Coverage Termination**. Questions regarding late notification are to be directed to your prior employer.

Failure to comply with the timeliness requirement will result in denial of your request to continue coverage.

Hartford Life
Attention: Portability Administration
P.O. Box248108
Cleveland, OH 44124-8108

Important Note: You may want to take the following information into consideration when deciding whether to apply for portability of coverage. Coverage under the group portability policy reduces and terminates upon reaching certain ages. Employee and spouse coverage reduces to 25% when reaching age 65. If you are age 65 or older when electing portability, your coverage will be immediately reduced to 25% of the amount that is eligible for portability. Additionally, coverage terminates when reaching age 75. A dependent child's coverage will terminate at age 19 unless they are a full time student, then coverage will terminate at age 25. Conversion is available upon termination of coverage. If you have questions about completing this enrollment form, you may call Hartford Life at **1-877-320-0484**.

PART B (to be completed by applicant)

Employee Name:	
Address:	
Town/State/ Zip Code:	
Daytime Phone Number:	()
Evening Phone Number:	()

Is any applicant **converting** any portion of coverage which terminated? Yes No If yes, please complete the following. **(You can not port and convert the same coverage.)**

Name	Coverage Type	Amount Being Converted
	<input type="checkbox"/> Basic <input type="checkbox"/> Supplemental	\$
	<input type="checkbox"/> Basic <input type="checkbox"/> Supplemental	\$

Coverage is requested to be continued for:

Name	Date of Birth	Social Security Number	Percentage of Insurance 50,75,100	Amount of Basic Life Insurance (If portable)	Portability Cost per Quarter	Amount of Supplemental Life Insurance (If portable)	Portability Cost per Quarter	Total Portability Cost per Quarter
				\$	\$	\$	\$	\$
				\$	\$	\$	\$	\$
				\$	\$	\$	\$	\$
				\$	\$	\$	\$	\$
				\$	\$	\$	\$	\$
							Grand Total:	\$

Please use the rate provided by your employer on page one to calculate your premiums.

Rate Calculation Example

Sam wishes to port \$100K of Life insurance coverage.

Her premium is:

Quarterly: \$100 x .93(Rate) = \$93.00

BENEFICIARY DESIGNATIONS:

Your prior group beneficiary designations do not apply to this coverage. You must identify the designated beneficiaries for all persons applying for coverage, except dependent children. The beneficiary for dependent children will automatically be the employee, if continuing coverage, or if the employee is not continuing coverage, the spouse.

It is important that your beneficiary designations be clearly understood. Hartford Life Insurance Company will consider all named beneficiaries to share equally in the proceeds unless you specify otherwise. To allocate a specific amount to a particular beneficiary, state the percentage, or share, next to that person's name.

You may also designate beneficiaries to be "primary" or "contingent". **Primary** beneficiaries are the persons who will receive the proceeds upon your death. **Contingent** beneficiaries are the persons who will receive the proceeds if the primary beneficiaries predecease you.

If your beneficiary is a trust, clearly indicate the name of the trust, and trustee if known, as well as the date the trust was established.

If you need assistance, contact your own legal counsel.

Insured Name	Beneficiary(ies) Name	Beneficiary's Social Security No.	Relationship	Age if a Minor	Share	Primary or Contingent
Example						
James Smith	Sally Smith	xxx-xx-xxx	Wife		100%	Primary
	Susie Smith	xxx-xx-xxx	Daughter	10	100%	Contingent
Employee						
Spouse						

I request to participate in the Hartford Group Insurance Trust in order to receive group life insurance. I have read this enrollment form and agree that all statements and answers are true and complete.

I understand that if any information stated in this enrollment form is incorrect, coverage may be rescinded and Hartford Life has no obligation to return any premium paid. I understand that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

I understand that no coverage will become effective until the enrollment form and premium amount has been approved and premiums have been received by Hartford Life Insurance Company. Evidence of insurability is not required to port your coverage, however, prior to policy issuance an eligibility check will be performed to determine the amount of coverage that may be converted.

I authorize my employer/former employer to release information about me required by The Hartford or their authorized agent to process my Portability enrollment form. This information may include but is not limited to my salary, amount of coverage including any applicable dependent coverage in effect when my coverage under the group plan ceased, job information, enrollment information, and beneficiary information.

Employee's Signature _____ Date _____

Spouse's Signature _____ Date _____
(If Applicable)