Diocese of La Crosse
St. Ambrose Financial Services

THE HARTFORD

NEW HIRE
LAY BENEFITS

EMPLOYER NAME *(PARISH - SCHOOL - INSTITUTION)*

LOCATION # *DOL*

GROUP # L06588 *SAFS USE ONLY: EFFECTIVE DATE*

PARTICIPANT INFORMATION

REQUIRED FOR ALL PAYROLL EMPLOYEES

First Name | Middle Initial | Last Name

Address | City | State | Zip Code

Phone Number | Personal Email | Birth Date

Social Security Number

Male | Female | Single | Married

Full Time Year Round | Part Time Year Round | Full Time School Year | Part Time School Year

Job Title | 1st Day of Work | Hours per Week

BASIC LIFE ELECTION: CHECK ONLY ONE

REQUIRED FOR ALL PAYROLL EMPLOYEES

- ○ I would like to ENROLL in Basic Life. I have filled out the following enrollment pages from The Hartford Group attached to this cover page.
- ○ I understand that I qualify for Basic Life, but I am WAIVING this benefit and may be denied in the future, even with an EOI.
- ○ I do not qualify for Basic Life. I work less than 30 hours per week.

VOLUNTARY LIFE ELECTION: CHECK ONLY ONE

REQUIRED FOR ALL PAYROLL EMPLOYEES

- ○ I would like to ENROLL in Voluntary Life. I have filled out the following enrollment pages from The Hartford Group attached to this cover page.
- ○ I understand that I qualify for Voluntary Life, but I am WAIVING this benefit and may be denied in the future, even with an EOI.
- ○ I do not qualify for Voluntary Life. I work less than 20 hours per week.

VOLUNTARY DISABILITY ELECTION: CHECK ONLY ONE

REQUIRED FOR ALL PAYROLL EMPLOYEES

- ○ I would like to ENROLL in Voluntary Disability I have filled out the following enrollment pages from The Hartford Group attached to this cover page.
- ○ I understand that I qualify for Voluntary Disability, but I am WAIVING this benefit and may be denied in the future, even with an EOI.
- ○ I do not qualify for Voluntary Disability. I work less than 20 hours per week.

Please continue to The Hartford enrollment pages to complete your benefit enrollment.

All pages, including this one, should be returned to SAFS by secure email, fax, or secure web upload on our website.

benefitssupport@stambrosefinancial.com
www.stambrosefinancial.com
(608) 787.8068

Participant Signature - Required

Date

Benefits Enrollment Form for Diocese of La Crosse
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.

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)	**SSN**	**Date of Birth** (MM/DD/YYYY)

Gender ☐ M ☐ F	**Email Address**

Street Address	**City**	**State**	**Zip Code**

Date of Hire (MM/DD/YYYY)	**Base Annual Earnings**

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

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

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**	**Monthly Premium Amount** (Cost per Pay Period – 12/Year)	**Elect Coverage or Continue Current**	**Decline Coverage**
Employee	60% of earnings, up to $5,000 each month	$_____	☐	☐

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.

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

Coverage for Employee Only	**Benefit Amount**	**Monthly Premium Amount** (Cost per Pay Period – 12/Year)	**Elect Coverage**	**Decline Coverage**
Employee	$30,000	See your benefit sheet	☐	☐

Additional Information:

- The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 65.

SUPPLEMENTAL 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**	**Monthly Premium Amount** (Cost per Pay Period – 12/Year)
Employee	☐ $10,000	$_____
	☐ $20,000	$_____
	☐ $150,000	$_____
	☐ $500,000 (Requires EOI*)	$_____
	☐ $_____	$_____
	☐ Decline Employee Coverage	N/A
Spouse	☐ $5,000	$_____
	☐ $10,000	$_____
	☐ $50,000	$_____
	☐ $100,000 (Requires EOI*)	$_____
	☐ $_____	$_____
	☐ Decline Spouse Coverage	N/A
Child(ren) • The premium amount(s) shown apply to all children, regardless of the number of children you have	☐ $10,000	$1.90 for all children
	☐ Decline Child(ren) Coverage	N/A

Additional Information:

- *If you elect an amount that exceeds the guaranteed issue amount of $150,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.
- *If you elect an amount that exceeds the guaranteed issue amount of $50,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.
- The premium amount(s) for you and your spouse 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.

EMPLOYEE NAME:_____

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.

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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 applications in New York): 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.

EMPLOYEE NAME:_____

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

THE HARTFORD

You must select your beneficiary – the person (or more than one person) or legal entity (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.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary 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 benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. 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 Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Doe	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box),* I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: X X X X X ☐ ☐ ☐ ☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer: Diocese of La Crosse		Policy Number: 922324

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)