Extended Continuation for Group Disability Income Insurance (Long Term Disability)

Hartford Life and Accident Insurance Company (A stock insurance company)

Home Office: Hartford, Connecticut · Phone: 877-320-0484

If you are enrolled for Long Term Disability (LTD) coverage under the group policy offered by your employer, that includes an "Extended Continuation" provision, we have good news!

Your coverage can help provide stability in an unstable time, by replacing part of your income and helping to cover your day-to-day living expenses, if you are unable to work for an extended period of time due to illness or injury. If your coverage under the group policy ends because of certain qualifying events (as defined in the Extended Continuation provision), you have the option to continue coverage by paying premiums directly to The Hartford.

All you need to do to do is complete the Extended Continuation request form included below and return it to us, along with a check or money order for the initial premium due.

Extended continuation is only available for the coverage type(s) you were insured for under the group policy. **Your completed request form and initial premium payment should be submitted within 31 days of the date coverage under the group policy would otherwise end.** In certain circumstances, requests for coverage and the initial premium due, may be accepted beyond 31 days. In any event, a request for continuation received more than 91 days after coverage under the group policy would otherwise end, will not be accepted under the terms of the policy.

ASKED & ANSWERED

Who is eligible? Employees represented by the New York State Nurses Association, who are enrolled for Long Term Disability coverage that includes the Extended Continuation provision. Please see your certificate of insurance along with any applicable certificate riders to determine if you are eligible.

When does coverage under this provision begin? If you are eligible and return your completed request form with the required premium payment, your coverage under the group policy will continue without interruption beyond the date it would have otherwise ended.

When does coverage under this provision end? Your coverage can be extended for a maximum of 60 months and is subject to all additional terms and conditions of the Extended Continuation provision and group policy. Please see your certificate of insurance along with any applicable certificate riders for additional details.

How do I pay for this coverage? The initial premium is payable via check or money order and must be provided along with your completed request form. You have the option to continue receiving paper bills and paying via check/money order, or you can choose to have future premiums paid with automated bank draft.

Where do I get a copy of my certificate of insurance? Please contact the benefits administrator of your former employer to request a copy. If you are unable to get a copy from your former employer, you may call us toll-free at 877-320-0484 for assistance.

NOTICES

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting company Hartford Life and Accident Insurance Company, under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.TheHartford.com. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the underwriting company listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

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 group 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.

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The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

INSURED INFORMATION (REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*))

Name* (FIRST MI LAST)	**SSN/Tax ID***	**Employer Name**
Date of Birth*	**Home Phone**	**Cell Phone**
Email Address		

Consent to Email and Phone Correspondence

☐ Check this box if you consent to receiving future correspondence regarding this request via email and/or phone.

CURRENT POLICY, COVERAGE & PREMIUM INFORMATION

Please contact your former employer to obtain the information below (if needed). Extended Continuation is only available for the coverage type(s) that you were insured for under the group policy.

Enter the amount of covered payroll you were insured for when your coverage under the group policy ended and the amount of monthly premium your former employer was paying for that coverage.

The amount of covered payroll under Extended Continuation cannot exceed the amount you were insured for when your coverage under the group policy ended.

Group Policy Information

Group Disability Income Insurance
(Long Term Disability)
Policy Number: 1715052

Coverage & Premium Information

Coverage Type	**Covered Payroll** (Monthly)	**Monthly Premium** ($.47 per $100 of covered payroll.)
Group Disability Income Insurance (Long Term Disability)		

BILLING OPTIONS & INITIAL PREMIUM PAYMENT CALCULATION

Billing Options:

- Quarterly (you will receive future bills every three months on an ongoing basis).
- Semi-Annual (you will receive a bill every six months on an ongoing basis).
- Annual (you will receive a bill every twelve months on an ongoing basis).

Billing Methods:

- If you select Direct Billed via Mail, you will receive a paper bill through traditional mail on an ongoing basis.
- If you select Automatic Payment Option (APO), you must also complete the SelmanCo APO Authorization Form on page 5. Your premium payments will then be automatically withdrawn from the bank account you designate, on an ongoing basis.

– FORM CONTINUES TO NEXT PAGE –

(1) Choose your preferred **Billing Option**:	☐ Quarterly ☐ Semi-Annual ☐ Annual
(2) Enter the **Monthly Premium** shown above:	
(3) Enter one of the following multipliers for the **Billing Option** you selected: • **3** for Quarterly • **6** for Semi-Annual • **12** for Annual	
(4) Multiply the **Monthly Premium** amount by the **Billing Option** multiplier to calculate the **Total Initial Premium Due** and enter that amount.	
(5) Choose your preferred future **Billing Method**:	☐ Direct Billed via Mail ☐ Automatic Payment Option (APO)

STEP 4: CONFIRMATION & SIGNATURE

By signing below, I confirm that I understand and agree to the following statements:

- Employees who are eligible for similar benefits under another group policy, will not be considered eligible for coverage continuation under the Extended Continuation provision.
- This request may be denied by The Hartford only for reasons stated in the group policy and/or certificate of insurance.
- This request must be received by The Hartford within 91 days of the date coverage under the group policy ends. Requests received **more than 91 days after the date coverage under the group policy ends will be denied**.
- Coverage continued under the Extended Continuation provision is subject to all other terms and conditions of the applicable group policy and certificate of insurance. Payment of premium does not ensure eligibility for benefits under the group policy.
- The initial premium payment is applied from the first day following the date your coverage under the group policy would otherwise end. The next premium payment will be due in accordance with the Billing Mode you select.

Signature	**Date of Signature**

FORM & PREMIUM SUBMISSION INSTRUCTIONS

1) Make the check or money order for your initial premium payment payable to "**The Hartford**." Please make sure your name is in included on the payment.

2) Mail the completed and signed form (pages 3-4) along with your initial premium payment, and completed APO form (page 5) if applicable, to:

   The Hartford Portability & Conversion Unit
   PO Box 43786
   Cleveland OH 44143-0786
   Fax: 440-646-9339

NOTE: Please keep a copy of this completed document for your records.

Automatic Payment Option (APO)

Savings or **Checking** Account Deduction Authorization Form

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1. **Insured's Information**
   Name of Insured _____ Insured's Date of Birth ___/___/____
   Insured's Street Address _____
   City_____ State_____ Zip Code _____
   Please list the Insurance Policy(ies) you wish to have premium deductions made from the account indicated below:
   Policy Number(s) _____ID Number(s):_____
   _____
2. **Financial Institution Information**
   Depositor Name (Payor) _____
   (As it appears on Financial Institution Records)
   Financial Institution Name _____ Account Number_____
   (Include Branch Name)
   Financial Institution City_____ State_____ Zip Code _____
3. **Account Selection:** I authorize an automatic deduction from my *(please choose one):*
   ❒ **Checking Account.** Attach a sample VOIDED check.
   ❒ **Savings Account.** Account Number: _____ Routing Number: _____

   Premium deduction should be made:
   ❒ **Monthly** ❒ **Quarterly** ❒ **Semi-Annually** ❒ **Annually**

4. **Signature/Authorization**

In accordance with the agreements and conditions listed below, I hereby request and authorize Selman & Company to initiate debit entries on the Financial Institution account listed herein for the purpose of paying premium. This authorization is to remain in full force and effect until Company and Depository have received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on such notification. Written notification must be mailed to: Selman & Company, One Integrity Parkway, Cleveland, OH 44143-1500.

Signature of **Depositor** _____
Print Name of **Depositor** _____ **Date** ____/____/____
Signature of **Applicant/Insured** *(If different from Depositor)* _____
Print Name of **Insured/Applicant** _____ **Date** ____/____/____

5. **Agreements & Conditions**

Automatic Payment Option (Account Deduction Authorization) is subject to the following conditions:

1. Premium payments will be debited from your account on or about the premium due date.
2. Additional premium that may be required in order to keep policy(ies)/certificate(s) current may be drawn from your account through the use of multiple debits.
3. Selman & Company (Company) may revoke the privilege of paying premium under this Automatic Payment Option (APO) if any payment is dishonored.
4. A service fee of $15.00 may be assessed for each dishonored payment.
5. Payment of premium under APO may be discontinued by the Company or the undersigned upon thirty (30) days written notice.
6. If APO is discontinued, an alternate payment mode acceptable to the Company will be used to remit the premiums needed to keep the policy(ies)/certificate(s) in force and current.
7. The Company will not send premium notices while APO is in effect.
8. A request for change or adjustment to the APO must be sent directly to the Company's Customer Service Department.
9. If you cancel this service, any refund of premium due you will take sixty (60) days to process.
10. Participation in the Sponsoring Organization may be required to maintain your coverage.
11. In the event the premium amount to be debited changes, you will be notified in writing at least 10 days before the new premium amount is debited.

1104APO

NOTE: Please keep a copy of this completed document for your records.