Extended Continuation for Accident, Critical Illness/ Specified Disease and/or Hospital Indemnity Insurance

Hartford Life and Accident Insurance Company (A stock insurance company)
Home Office: Hartford, Connecticut Phone: 877-320-0484

EXTENDED CONTINUATION INFORMATION

If you were enrolled for coverage in a group accident insurance, group critical illness insurance (also called group specified disease insurance in NY) or group hospital indemnity insurance plan offered by an employer (or other group) that includes an "Extended Continuation" provision, we have good news!

Your coverage pays cash benefits that help you and your loved ones manage expenses and maintain your lifestyle following a covered accident, diagnosis of a covered illness, or hospitalization. When a qualifying event occurs under your group plan (as defined by the group policy(ies)), you have the option to continue this valuable coverage by paying premiums directly to The Hartford.

All you need to do to continue coverage is complete the "Extended Continuation Request Form for Accident, Critical Illness/Specified Disease and/or Hospital Indemnity Insurance" that follows. Return the form starting on page 3 along with a check or money order for the initial premium due (quarterly). Please be sure to select the billing mode that you want after your initial payment.

Extended continuation is only available for the coverage type(s) that you were insured for under your group plan. **Your request form and initial premium payment should be submitted within 31 days from the date insurance under the group policy(ies) would otherwise end.** An extension of the request period is available in certain circumstances. In any event, a request for continuation received more than 91 days after insurance under the group policy(ies) would otherwise end will not be accepted.

We look forward to keeping you protected and thank you for your business!

ASKED & ANSWERED

Who is eligible? Anyone insured under the group policy(ies) at the time of the qualifying event is eligible under the extended continuation provision, subject to the following: 1) the primary insured under extended continuation must be younger than the termination age of the plan to be eligible; and 2) your dependent child(ren) must satisfy the dependent child definition of the policy to be eligible. Your coverage tier may change (from what you had as an active employee/member under the plan) based on who is eligible when you request extended continuation.

Who is the "primary insured?" If the employee/member under the group plan is eligible to request continuation, then the employee/member is the primary insured under the extended continuation provision. If the spouse/partner under the group plan is eligible to elect continuation (in the event of divorce/legal separation from or death of the employee/member), then the spouse/partner is the primary insured under the extended continuation provision.

When does this insurance under the extended continuation provision begin? If your request and initial premium is accepted, insurance under this provision begins the first day of the month following the day insurance under the group plan would otherwise end. Your initial premium payment is applied from this date. Please see the applicable policy for additional information.

When does this insurance under this provision end? This insurance will end when an insured person no longer satisfies the eligibility conditions, or when the primary insured reaches the termination age, of the applicable policy. Insurance under this provision will also end if at any time the policyholder terminates the group policy. Other circumstances under which insurance will end are described in the certificate.

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.[1] All you have to do is request the coverage to remain insured.

How do I pay for this insurance? Your initial premium payment is payable via check or money order at the time you request continuation, as indicated on the request form. Upon receipt of subsequent bills, you will 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(s)? The certificate that applies to each coverage is the same certificate that is in effect for the group plan. Please contact the benefits administrator of your former employer/group to request a copy. If you are unable to get a copy from your former employer/group, you may call us toll-free at 877-320-0484 for assistance.

Are there any options for me to continue insurance if the group policy is terminated by the employer/group? Yes. If your coverage under an extended continuation provision is terminated because a group policy is terminated, you may be able to request coverage through the applicable portability policy. (Portability is not available in some states.)

If you prefer, in lieu of extended continuation, you may be able to request coverage through portability right now. Under both The Hartford's portability policies, you have a choice of three plan designs each with varying levels of benefits. This choice allows you the flexibility to enroll for the coverage that best meets your current financial protection needs. E-mail us at http://info.selmanco.com/hartford-forms to obtain portability request forms, or call us toll-free at 877-320-0484.

BENEFICIARY DESIGNATION FOR ACCIDENT & HOSPITAL INDEMNITY INSURANCE

To ensure our records are current, we recommend that you complete and submit a beneficiary designation form for accident and/or hospital indemnity insurance, if you are electing to continue insurance. In the unfortunate event of your death, maintaining a current beneficiary designation ensures that any benefits due and unpaid to you at the time of your death are distributed as you intend. A beneficiary designation form is included in this forms package for your convenience.

ACCIDENT INSURANCE NOTICES

THE POLICY IS A LIMITED ACCIDENT ONLY POLICY.

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

This limited health 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 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.

CRITICAL ILLNESS INSURANCE NOTICES

THE POLICY PROVIDES LIMITED BENEFITS FOR SPECIFIED DISEASES ONLY. This limited health 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 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) may not be eligible for this insurance.

HOSPITAL INDEMNITY INSURANCE NOTICES

THE POLICY IS A HOSPITAL CONFINEMENT INDEMNITY POLICY. THE POLICY PROVIDES LIMITED BENEFITS. This limited health 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 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) may not be eligible for this insurance.

GENERAL NOTICES

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing 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 provision 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.

[1]**Critical illness/specified disease insurance and hospital indemnity insurance are guaranteed issue, but do contain a Pre-Existing Condition Limitation. Please refer to the applicable certificate for more information on exclusions and limitations, such as Pre-Existing Conditions.**

Extended Continuation Request Form for Accident, Critical Illness/ Specified Disease and/or Hospital Indemnity Insurance

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INSURED INFORMATION

Primary Insured Name* (FIRST MI LAST)		**Group/Employer City Name**	
		GMA	
Policy Number(s)	**CI: 681159**	**ACC: N/A**	**HI: N/A**

STEP 1: OBTAIN CURRENT COVERAGE & PREMIUM INFORMATION

Pleasecontactyourformeremployertoobtaintheinformationbelow(ifneeded).Extendedcontinuationisonlyavailableforthecoverag type(s) that you were insured for under the policyholder's/your former employer's plan.

Please enter below the Coverage Tier that you were insured for under the policyholder's/former employer's plan and the am Child(ren), or Family.

Current Coverage & Premium Information

Coverage Type	**Coverage Tier**	**Coverage Amount**	**Current Monthly Premium**
Accident (AI)		N/A	
Critical Illness/Specified Disease (CI)			
Hospital Indemnity (HI)		N/A	

STEP 2: INITIAL PREMIUM PAYMENT CALCULATION

Please complete each line below as instructed for each coverage type that you were insured for under the policyholder's/former employer plan.

	AI	**CI**	**HI**
(1) Enter the Current Monthly Premium shown above for each Coverage Type available to you:			
(2) The initial first quarter premium is required. (You may select your future Billing Mode later on page 5)		3	
(3) Multiply the monthly amount for each coverage in line 1 by the billing multiplier in line 2 to calculate the initial premium due for each Coverage Type.			
(4) Add the amounts across on line 3 together (if requesting multiple coverages) or reenter the amount from line 3 (if electing only 1 coverage) for the **Total Initial Premium Due.**			

PREMIUM REMITTANCE FORM SUBMISSION

Enter the Total Initial Premium Due from line 4 above onto the remittance form on Page 5.

Extended Continuation Beneficiary Designation for Accident and/or Hospital Indemnity Insurance

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INSURED INFORMATION		
Primary Insured Name* (FIRST MI LAST)	**Last 4 of SSN/Tax ID***	**Group/Employer Name**
Policy Number(s)	**ACC:**	**HI:**

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

This designation is for any benefits payable while insured through an extended continuation provision for accident and/or hospital indemnity insurance, which are due and unpaid at the time of your (the primary insured's) death. This beneficiary designation replaces an (POA).

All information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits eq name.

Certain states are community property states. If you live in one of these states – AK, AR, CA, ID, LA, NV, NM, TX, WA or WI – and desig 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 confirm that I understand and agree to the following statements:

- This beneficiary designation applies only to benefits payable while I am insured through an extended continuation provision for accident and/or hospital indemnity insurance issued to me by The Hartford.
- This beneficiary designation is subject to change as provided in the applicable group policy.
- This beneficiary designation is effective as of the date submitted.
- I reserve the right to change the beneficiary(ies) without consent of said beneficiary(ies).

Primary Insured Signature	**Date of Signature**

FORM SUBMISSION INSTRUCTIONS

1) Submit this completed and signed form to The Hartford as soon as possible after insurance has been requested under an extended continuation provision. You should mail it with your premium remittance form and payment.
2) Mail the form to: The Hartford Portability & Conversion Unit
   PO Box 43786 Fax 1-440-646-9339
   Cleveland OH 44143-0786 https://info.selmanco.com/hartfordnocp
3) Keep a copy of the completed form for your records.

Extended Continuation Premium Remittance Form for Accident, Critical Illness/ Specified Disease and/or Hospital Indemnity Insurance

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Extended Continuation Premium Remittance Form (REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*))

Insured Information

Primary Insured Name* (FIRST MI LAST)	**Gender*** c M c F	**SSN/Tax ID***	**Group/Employer Name**
Date of Birth*	**Home Phone**		**Cell Phone**
Email Address	**Married/Partnered*** c Yes c No		**Applicant Type*** c Employee/Member c Spouse/Partner

Consent to Email and Phone Correspondence
c Check this box if you consent to receiving future correspondence regarding this request via email and/or phone.

Address for Future Billing

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

DEPENDENT INFORMATION (COMPLETE FOR ANY DEPENDENTS THAT ARE TO BE INSURED UNDER THE POLICY)

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

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

Coverage Request & Premium Due

Coverage Type*	**Coverage Tier***	**Coverage Amount***	**Future Billing Mod One***	**Future Billing Optio One***	**Total Initial Premium Due*** **(amount from page 3)**
c Accident		N/A	c Quarterly c Semi-Annual c Annual	c Direct Billed c Electronic Funds T the separate EFT form)	
c Critical Illness					
c Hospital Indemnity		N/A			

STEP 3: PREMIUM REMITTANCE FORM SUBMISSION

1) Select the ongoing Billing Mode above that you prefer by checking the box for one billing mode option. If you select Quarterly, you will receive a bill every 3 months on an ongoing basis. If you select Semi-Annual, you will receive a bill every 6 m basis.
2) Make your check or money order for the total due payable to "**The Hartford**." Be sure to include the Primary Insured's name on the payment.
3) Mail your payment with the completed request form, remittance form and beneficiary designation form (if HI/ACC elected) to The Hartford as soon as possible (no more than 91 days) after insurance would otherwise end under the policyholder's/your former employer's plan.
4) Mail all forms and payment to: The Hartford Portability & Conversion Unit
PO Box 43786 Fax 1-440-646-9339
Cleveland OH 44143-0786 https://info.selmanco.com/hartfordnocp

Primary Insured Signature	**Date of Signature**