Hartford Life and Accident Insurance Company, One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)

UNION PLUS GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE ENROLLMENT FORM

1. ☐ (Initial here) **YES**, I hereby enroll in the Accidental Death and Dismemberment Insurance offered by Union Plus.

Please check desired coverage (✔)

Monthly Rates

Benefit Amount*	Union Member Only	Union Member and Family
$200,000	☐ $22.90	☐ $17.07
$100,000	☐ $9.19	☐ $12.10
$50,000	☐ $5.24	☐ $6.70

All coverage is reduced by 50% at age 70 or older. This reduction also applies even if you have attained the age of 70 when you first obtained the coverage. If you select a credit card or automatic withdrawal from your banking account (ACH), as your payment method, your premiums will be charged monthly. If you receive paper bills, you will be billed on a quarterly basis. Rates and/or benefits may be changed on a class basis. Spouse/domestic partner coverage is 50% of union member's selected coverage, children's coverage is 10% of union member's selected coverage.

My Beneficiary for coverage selected _____
(first, middle, last)

2. Member's Date of Birth ✘ _____
(mo / day / yr)

Preferred Phone Number _____

Email Address (optional) _____

☐ Please email me updated information about Union Plus insurance products.
☐ Please email me updates and E-news about other Union Plus benefits.

First name _____
Last name _____
Address line 1 _____
Address line 2 _____
City _____ State _____ Zip _____
Email Address _____
Union _____
Local union number _____
Spouse First name _____
Spouse Last name _____

3. Confirmation:

I acknowledge that I have been given the opportunity to enroll in the Accidental Death and Dismemberment Insurance Plan. I certify that I am a member/spouse of a member of the union and that the above information is true and complete to the best of my knowledge.

I understand and agree that the 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 Union Plus (ADD-9920) 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.

I understand that at age 70, or if I am already age 70, all coverage is reduced by 50%.

Member Signature ✘ _____ Date ✘ _____

Spouse Signature _____ Date _____
(if enrolling)

Underwritten by: Hartford Life and Accident Insurance Company
Hartford, CT 06155
Policyholder: AFL-CIO Mutual Benefit Fund

TO ENROLL: Please make check payable to: AFL-CIO Mutual Benefit Fund. Mail it along with your completed Enrollment Form to Union Plus Insurance Program, PO Box 47060, Phoenix, AZ 85068-7060.
Questions? Call 1-866-557-5209 8AM – 7PM EST, Mon-Fri.

Please continue to next page ...

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 information 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 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 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.