



**GROUP INSURANCE APPLICATION**

Application is hereby made to Hartford Life Insurance Company ("HL") on the basis of the information contained in this application, the group risk specifications, the enrollment data, and available experience data. The application in its entirety, and any required additional information, is subject to Home Office approval before insurance can become effective.

If this application is approved by HL's Home Office, it will be attached to and made part of the Group Policy(ies). Insurance will become effective on the requested effective date shown below, unless HL sends written notice of a different effective date.

If this application is not approved by HL's Home Office, no insurance is in effect at any time, and any deposit premium HL has received will be returned.

This application is made with the following deposit premium. The premium amount is estimated, as the amount due for the first month, and will be applied toward the first premium on the proposed Group Policy(ies): \$ \_\_\_\_\_

If any insurance requires employee contributions, any underwriting requirements for enrollment must be met before insurance can become effective.

Requested effective date: \_\_\_\_\_

Coverages being applied for:

Life                       AD&D                       Short Term Disability                       Long Term Disability  
 Other: \_\_\_\_\_

W-2 Services Option (for Short Term Disability and Long Term Disability coverage only)

- Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.
- Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established standard procedures.

Are there any companies that are subsidiaries or affiliates of the applicant, which are also to be insured? If yes, please furnish a listing, giving the name, address, effective date of coverage, and number of employees for each such company.  Yes  No

Is the benefit plan, for which insurance is being requested, subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended?  Yes  No

If yes, identify the Plan Number: \_\_\_\_\_

Sales Representative for HL: \_\_\_\_\_

Regional Office: \_\_\_\_\_

Name of Agent/Broker: \_\_\_\_\_

**For Applicant:** \_\_\_\_\_

Legal Name of Entity

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Title of Authorized Signer

\_\_\_\_\_  
Employer Tax ID No.