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 and NC) 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 along with a check or money order for the initial premium due as selected by you.

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 request 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 applicable 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 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 hartfordreps@selmaninsurance.com to obtain portability request forms, or call us toll-free at 877-320-0484.

BENEFICIARY DESIGNATION

To ensure our records are current, we recommend that you complete and submit a beneficiary designation form for any continued insurance that allows a beneficiary designation. 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 form package for your convenience. Please note that not all policies allow for a beneficiary designation. Please refer to each applicable certificate for clarification.

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 may include 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

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

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

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STEP 1: INSURED INFORMATION (REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*))

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

Consent to Email and Phone Correspondence

☐ 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 COVERAGE)

Spouse/Domestic Partner Name* (FIRST MI LAST) ☐ N/A	**Date of Birth***	**Date Married/Partnered***

Child Name* (FIRST MI LAST)	**Date of Birth***	**Relation***	**Child Name*** (FIRST MI LAST)	**Date of Birth***	**Relation***

STEP 2: OBTAIN 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 your prior group plan.

In this step, enter the Coverage Tier for each product/coverage you were insured for and the amount of monthly premium you were paying for that coverage. Possible Coverage Tiers include Employee Only, Employee + Spouse/Partner, Employee + Child(ren) or Family.

Group/Employer Policy Information

Accident Policy Number	**Critical Illness/Specified Disease Policy Number**	**Hospital Indemnity Policy Number**

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 3: COVERAGE REQUEST, BILLING SELECTION & INITIAL PREMIUM PAYMENT CALCULATION

Help with Billing Modes:

- If you select Quarterly, you will receive a bill every three (3) months on an ongoing basis.
- If you select Semi-Annual, you will receive a bill every six (6) months on an ongoing basis.
- If you select Annual, you will receive a bill every twelve (12) months on an ongoing basis.

Help with Billing Options:

- 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), your ongoing payments will be automatically withdrawn from the bank account you designate on an ongoing basis. You must complete the SelmanCo Automatic Payment Option (APO) Authorization Form included in this form package to complete this option. If you choose this option but do not complete the APO form, you will receive paper bills until such time as the APO form is completed.

– FORM CONTINUES TO NEXT PAGE –

STEP 3: COVERAGE REQUEST, BILLING SELECTION & INITIAL PREMIUM PAYMENT CALCULATION (CONT'D)			
	AI	**CI**	**HI**
(1) Check the box for each Coverage Type you choose to continue: *Reminder: You may only continue coverage that you were insured for under your prior group plan.*	☐	☐	☐
(2) Enter the Current Monthly Premium shown above for each Coverage Type you choose to continue:			
(3) Enter the multiplier for the Billing Mode you select. Use 3 for Quarterly, 6 for Semi-Annual and 12 for Annual:			
(4) Multiply the monthly amount (2) by the billing multiplier (3) to calculate the initial premium due for each Coverage Type you choose to continue:			
(5) Add the amounts on line (4) together (if requesting multiple coverages) or reenter the amount from line (4) (if electing only one coverage) for the **Total Initial Premium Due:**			
(6) Choose your preferred future Billing Option:	☐ 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:

- This request is subject to review and acceptance by The Hartford, and may be denied by The Hartford.
- This request must be received by The Hartford within 91 days of the date that the applicable insurance ceased under the primary insured's former group plan. Requests received **more than 91 days after insurance under the group plan ceased will be denied**.
- If this request is accepted by The Hartford, this insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the applicable policy and certificate.
- The individuals covered under Extended Continuation must satisfy the policy's requirements to be eligible for benefits. Payment of premium does not ensure eligibility for insurance.
- If this request is accepted by The Hartford, the initial premium payment is applied from the first day of the month following the date that the applicable insurance ceased under the former group plan. The next premium payment will be due by the first day of the fourth month following the day the applicable insurance under the group plan ended.
- If any premium is collected after eligibility for insurance ceases, the unearned premium will be refunded in accordance with the terms of the policy.
- Premium amounts may increase if the experience of the policy requires a change for all individuals insured under the policy.

Primary Insured Signature	**Date of Signature**

STEP 5: FORM & PREMIUM SUBMISSION INSTRUCTIONS

1) Submit this completed and signed form (pages 3-4) with the initial premium payment (the **Total Initial Premium Due**) to The Hartford.
2) Make the check or money order for the initial premium payment payable to "**The Hartford**." Be sure to include the primary insured's name on the payment.
3) Mail this request form, the beneficiary designation form (page 5, if designating a beneficiary at this time), the APO form (page 6, if requesting future APO (bank draft) premium billing at this time) and payment to:
   The Hartford Portability & Conversion Unit
   PO Box 43786
   Cleveland OH 44143-0786
   Fax: 440-646-9339
4) Keep a copy of the completed forms for your records.

Extended Continuation Beneficiary Designation

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

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

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THE HARTFORD

INSURED INFORMATION

Primary Insured Name* (FIRST MI LAST)	**Last 4 of SSN/Tax ID***	**Group/Employer Name**

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, critical illness/specified disease and/or hospital indemnity insurance:

- which are due and unpaid at the time of your (the primary insured's) death; and
- for which the applicable policy allows for benefits to be paid to a beneficiary. (Please note that not all policies allow for a beneficiary designation. Please refer to each applicable certificate for clarification.)

This beneficiary designation replaces any prior designation made by you for the applicable coverage through The Hartford. This designation may be changed upon written request. Please note that in no event may a beneficiary be changed by a power of attorney (POA).

All information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless percentages are stated below. **The percentages must total 100%** for all Primary Beneficiaries and 100% for all Contingent Beneficiaries. If you need to designate more beneficiaries than space will allow, please include the additional information on separate paper and submit it with this form, clearly stating your 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 designate someone other than your spouse as your beneficiary, state law may require that your spouse consent to the designation. Puerto Rico and certain tribal jurisdictions may also require spousal consent. Please consult your legal advisor for additional 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 may mail it with your request form and initial premium payment, if you desire.
2) Mail the form to: The Hartford Portability & Conversion Unit
   PO Box 43786
   Cleveland OH 44143-0786
3) As an alternative, you may fax this beneficiary designation form to 440-646-9339.
4) Keep a copy of the completed form for your records.

SelmanCo

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, Ohio 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.

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

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