HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

THE HARTFORD | UNION PLUS

Hospital Indemnity Insurance Plan Enrollment Form

Exclusively for union members ages 18 to 64

Group Policyholder: AFL-CIO Mutual Benefit Fund **Policy Number:** AGP-40000

SECTION 1 | Member Information

Member's Name:		Union Membership Number:	
Street:	City: State: Zip Code:		
Member's Social Security Number:		Member's Date of Birth:	Gender: ❑ Male ❑ Female
Email Address:		Preferred Phone Number:	

SECTION 2 | Spouse/Domestic Partner Information

Is Spouse/Domestic Partner's Coverage Desired? ❑ Yes ❑ No

Spouse/Domestic Partner's Full Name (if enrolling)

Spouse/Domestic Partner's Social Security Number:	Spouse/Domestic Partner's Date of Birth:	Gender: ❑ Male ❑ Female

SECTION 3 | Dependent Children Information *(if enrolling). If more than 4 children, attach additional sheet.*

Child's name:	Date of Birth:	Child's name:	Date of Birth:
Child's name:	Date of Birth:	Child's name:	Date of Birth:

SECTION 4 | Coverage Information

❑ **YES,** enroll me in the Union Plus Hospital Indemnity Insurance Plan.
I understand I have 30 days to review my Certificate at no risk.

I hereby enroll in the following coverage level *(check only one)*	I hereby select benefits for *(check all that apply)*
❑ Low coverage	❑ Member
❑ Medium coverage	❑ Spouse/Domestic Partner
❑ High coverage	❑ Dependent child(ren) under age 19 (under 26 if a student)

Age reduction
The Benefit Amount(s) Payable for each Covered Person will decrease by 50% on the Premium Due Date on or next following the date the Member attains age 80.

SECTION 5 | Confirmation

I hereby confirm my enrollment in the Union Plus Hospital Indemnity Insurance Plan. Please process my enrollment form and send my Certificate of Insurance immediately. I understand I must be a union member to be eligible for coverage. I hereby certify that the above statements are complete and true to the best of my knowledge. I understand that this Hospital Indemnity Plan will not cover pre-existing conditions (conditions for which I received medical advice or treatment within 12 months) until the coverage has been in effect for 12 months. I understand the above coverage will become effective on the first day of the month following receipt of my enrollment form and first premium payment. I further understand that new conditions will be covered immediately.

I hereby attest that I have major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the Affordable Care Act.

Form PA-9751

Hospital Indemnity Form Series includes GBD-2800, GBD-2900, or state equivalent.

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SECTION 5 | Confirmation *(continued)*

Do you wish to receive your Certificate of Insurance by secure email? ❑ Yes ❑ No

If the "Yes" checkbox is selected, please provide your email address:

Member's Signature:	Date:
Spouse/Domestic Partner's Signature:	Date:

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Coverage will be issued upon receipt of this form and will begin when your first premium is received. However, insurance benefits payable are subject to the policy's Pre-Existing Conditions Limitation. You're covered immediately for ALL new health conditions and any current health conditions you have will be covered fully after 12 months. Please refer to the enclosed brochure for more information on exclusions and limitations, such as pre-existing conditions.

SECTION 6 | Fraud Notice(s)

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 Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

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 Mexico: 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 civil fines and criminal penalties.

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 New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For Residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Residents of Virginia: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or who files a claim containing a false or deceptive statement may have violated state law.

For Residents of Washington: 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.