SUPPLEMENTAL HEALTH BENEFICIARY DESIGNATION FORM INSTRUCTIONS

THE HARTFORD

You must select your beneficiary for your Supplemental Health coverage with The Hartford. Your beneficiary is the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your Hartford group Supplemental Health Insurance which may include Critical Illness, Accident, and/or Hospital Indemnity Insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee group Supplemental Health Insurance may be changed at any time upon written request received by us prior to your death.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Doe	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

Clear Form

SUPPLEMENTAL HEALTH BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box),* I hereby revoke any previous beneficiary designation(s), if any, for my Hartford group Supplemental Health insurance which may include Critical Illness, Accident, and/or Hospital Indemnity Insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: X X X X X ☐ ☐ ☐ ☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer:		Policy Number:

NAMING YOUR GROUP SUPPLEMENTAL HEALTH BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, or as indicated by the Policy

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (____) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Community property rights do not apply to benefits provided under an employee welfare benefit plan governed by ERISA.
Spousal Consent For Community Property States Only: If you live in a jurisdiction that recognizes a spouse's community property right or election, your spouse may have a community property interest in the benefit, unless waived. By signing below, your spouse waives his or her rights to any community property interest in the benefit. The community property jurisdictions are: Arizona, California, Guam, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, Wisconsin and certain tribal jurisdictions.
Spousal Consent: This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group Supplemental Health insurance issued by The Hartford, which may include Critical Illness, Accident, and/or Hospital Indemnity Insurance under the above policy, and waive any rights I may have to the proceeds of such insurance. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)