# GROUP VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

In the U.S., a disabling injury occurs every second, and an accidental death occurs every 4 minutes.[1]

## Florida Department of Transportation

Group Voluntary Accidental Death & Dismemberment (AD&D) insurance pays your beneficiary a death benefit if you die due to a covered accident or pays you if you are unexpectedly injured in a covered accident. The benefits are paid in lump sum amounts to you (or your beneficiary), and can be used to pay for health care expenses not covered by your major medical insurance, help replace income lost while not working, funeral expenses, or however you choose. Accidental death benefits are paid in addition to any life insurance.

To learn more about AD&D insurance, visit **thehartford.com/employeebenefits**

## COVERAGE INFORMATION

| APPLICANT | AD&D COVERAGE | | |
|---|---|---|---|
| **Employee** | Benefit[2]: Increments of $5,000<br>Maximum: $500,000 | | |
| **Dependent(s)** | Your dependent(s) will be covered at a percentage of your coverage amount. | | |
| | **COVERAGE TIER** | **SPOUSE PERCENTAGE** | **CHILD(REN) PERCENTAGE** |
| | **Spouse** | 50% | 0% |
| | **Child(ren)** | 0% | 15% |
| | **Spouse & Child(ren)** | 40% | 10% |

| AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT | |
|---|---|
| Covered accidents or death can occur up to 365 days after the accident. The total benefit for all losses due to the same accident will not exceed 100% of your coverage amount. | |
| **LOSS FROM ACCIDENT** | **COVERAGE AMOUNT** |
| Life | 100% |
| Both Hands or Both Feet or Sight of Both Eyes | 100% |
| One Hand and One Foot | 100% |
| Speech and Hearing in Both Ears | 100% |
| Either Hand or Foot and Sight of One Eye | 100% |
| Movement of Both Upper and Lower Limbs (Quadriplegia) | 100% |
| Movement of Both Lower Limbs (Paraplegia) | 75% |
| Movement of Three Limbs (Triplegia) | 75% |
| Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia) | 50% |
| Either Hand or Foot | 50% |
| Sight of One Eye | 50% |
| Speech or Hearing in Both Ears | 50% |
| Movement of One Limb (Uniplegia) | 25% |
| Thumb and Index Finger of Either Hand | 25% |

[2]Your benefit will be reduced by 35% at age 70, 55% at age 75, 70% at age 80 and 85% at age 85 and 50% at age 70. Reductions will be applied to the current amount (after all previous reductions).

## PREMIUMS

See the Premium Worksheet.[2]

## ASKED & ANSWERED

### WHO IS ELIGIBLE?

You are eligible for this insurance if you are an active full-time employee, excluding OPS and temporary employees, who works at least 30 hours per week on a regularly scheduled basis.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

### 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.

### HOW DO I PAY FOR THIS INSURANCE?

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing payment.

### WHEN CAN I ENROLL?

You may enroll from November 1, 2020 to November 30, 2020.

### WHEN DOES THIS INSURANCE BEGIN?

The effective date of this coverage is January 1, 2021.

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility).

### WHEN DOES THIS INSURANCE END?

This insurance will end when you or your dependent(s) no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

### CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this coverage with you. Coverage may be continued for you and your dependent(s) under an individual conversion certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion are described in the certificate.

[1]Injury Facts. National Safety Council. 2015 Edition. P. 37. Web. 30 June 2017.
[3]Rates and/or benefits may be changed.

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# LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

## GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- The amount of coverage may be reduced at certain ages for you and your spouse.
- This insurance does not cover losses caused by:
  - Sickness; disease; or any treatment for either
  - Any infection, except certain ones caused by an accidental cut or wound
  - Intentionally self-inflicted injury, suicide or suicide attempt
  - War or act of war, whether declared or not
  - Injury sustained while in the armed forces of any country or international authority
  - Injury sustained on aircraft in certain circumstances
  - Taking prescription or illegal drugs unless prescribed by or administered by a licensed physician
  - Injury sustained while riding, driving, or testing any motor vehicle for racing
  - Injury sustained while committing or attempting to commit a felony
  - Injury sustained while driving while intoxicated
  - You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependent(s) when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Child(ren) may only be covered as a dependent of one employee.

THIS IS LIMITED ACCIDENT ONLY COVERAGE

DEFINITIONS

- Loss means, with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to sight, speech or hearing, entire and irrecoverable loss thereof; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints; with regard to movement, complete and irreversible paralysis of such limbs.
- Injury means bodily injury resulting directly from an accident, independent of all other causes, which occurs while you or your dependent(s) have coverage.

# Premium Worksheet


Rates and/or benefits can change.

## VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

**Bi-Weekly Premium Amount** (Cost per Pay Period – 26/Year)

| Benefit Amount | Employee Only | Employee & Family | Benefit Amount | Employee Only | Employee & Family | Benefit Amount | Employee Only | Employee & Family |
|---|---|---|---|---|---|---|---|---|
| $10,000 | $0.30 | $0.44 | $180,000 | $5.40 | $7.98 | $350,000 | $10.50 | $15.51 |
| $15,000 | $0.45 | $0.66 | $185,000 | $5.55 | $8.20 | $355,000 | $10.65 | $15.73 |
| $20,000 | $0.60 | $0.89 | $190,000 | $5.70 | $8.42 | $360,000 | $10.80 | $15.95 |
| $25,000 | $0.75 | $1.11 | $195,000 | $5.85 | $8.64 | $365,000 | $10.95 | $16.17 |
| $30,000 | $0.90 | $1.33 | $200,000 | $6.00 | $8.86 | $370,000 | $11.10 | $16.39 |
| $35,000 | $1.05 | $1.55 | $205,000 | $6.15 | $9.08 | $375,000 | $11.25 | $16.62 |
| $40,000 | $1.20 | $1.77 | $210,000 | $6.30 | $9.30 | $380,000 | $11.40 | $16.84 |
| $45,000 | $1.35 | $1.99 | $215,000 | $6.45 | $9.53 | $385,000 | $11.55 | $17.06 |
| $50,000 | $1.50 | $2.22 | $220,000 | $6.60 | $9.75 | $390,000 | $11.70 | $17.28 |
| $55,000 | $1.65 | $2.44 | $225,000 | $6.75 | $9.97 | $395,000 | $11.85 | $17.50 |
| $60,000 | $1.80 | $2.66 | $230,000 | $6.90 | $10.19 | $400,000 | $12.00 | $17.72 |
| $65,000 | $1.95 | $2.88 | $235,000 | $7.05 | $10.41 | $405,000 | $12.15 | $17.94 |
| $70,000 | $2.10 | $3.10 | $240,000 | $7.20 | $10.63 | $410,000 | $12.30 | $18.17 |
| $75,000 | $2.25 | $3.32 | $245,000 | $7.35 | $10.86 | $415,000 | $12.45 | $18.39 |
| $80,000 | $2.40 | $3.54 | $250,000 | $7.50 | $11.08 | $420,000 | $12.60 | $18.61 |
| $85,000 | $2.55 | $3.77 | $255,000 | $7.65 | $11.30 | $425,000 | $12.75 | $18.83 |
| $90,000 | $2.70 | $3.99 | $260,000 | $7.80 | $11.52 | $430,000 | $12.90 | $19.05 |
| $95,000 | $2.85 | $4.21 | $265,000 | $7.95 | $11.74 | $435,000 | $13.05 | $19.27 |
| $100,000 | $3.00 | $4.43 | $270,000 | $8.10 | $11.96 | $440,000 | $13.20 | $19.50 |
| $105,000 | $3.15 | $4.65 | $275,000 | $8.25 | $12.18 | $445,000 | $13.35 | $19.72 |
| $110,000 | $3.30 | $4.87 | $280,000 | $8.40 | $12.41 | $450,000 | $13.50 | $19.94 |
| $115,000 | $3.45 | $5.10 | $285,000 | $8.55 | $12.63 | $455,000 | $13.65 | $20.16 |
| $120,000 | $3.60 | $5.32 | $290,000 | $8.70 | $12.85 | $460,000 | $13.80 | $20.38 |
| $125,000 | $3.75 | $5.54 | $295,000 | $8.85 | $13.07 | $465,000 | $13.95 | $20.60 |
| $130,000 | $3.90 | $5.76 | $300,000 | $9.00 | $13.29 | $470,000 | $14.10 | $20.82 |
| $135,000 | $4.05 | $5.98 | $305,000 | $9.15 | $13.51 | $475,000 | $14.25 | $21.05 |
| $140,000 | $4.20 | $6.20 | $310,000 | $9.30 | $13.74 | $480,000 | $14.40 | $21.27 |
| $145,000 | $4.35 | $6.42 | $315,000 | $9.45 | $13.96 | $485,000 | $14.55 | $21.49 |
| $150,000 | $4.50 | $6.65 | $320,000 | $9.60 | $14.18 | $490,000 | $14.70 | $21.71 |
| $155,000 | $4.65 | $6.87 | $325,000 | $9.75 | $14.40 | $495,000 | $14.85 | $21.93 |
| $160,000 | $4.80 | $7.09 | $330,000 | $9.90 | $14.62 | $500,000 | $15.00 | $22.15 |
| $165,000 | $4.95 | $7.31 | $335,000 | $10.05 | $14.84 | | | |
| $170,000 | $5.10 | $7.53 | $340,000 | $10.20 | $15.06 | | | |
| $175,000 | $5.25 | $7.75 | $345,000 | $10.35 | $15.29 | | | |



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CREATION DATE: 8/29/2020

FLORIDA DEPARTMENT OF TRANSPORTATION/S05630/00114429

# Benefits Enrollment Form for Florida Department of Transportation
# Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.


**Instructions: 1)** Please print clearly with blue or black ink and provide complete information. (Missing information causes delays.) **2)** Please review the applicable benefit highlight/summary information for each product prior to electing coverage. You (employee) and your dependent(s) (if applicable) are only eligible for coverage as allowed by the applicable group policy. **3)** For each coverage, please check the appropriate box(es) to elect or decline coverage and enter amounts where necessary. **4)** Please sign and date the form. **5)** Submit the form as instructed by your benefits administrator. (Do not submit or send the form directly to The Hartford.)

## EMPLOYEE INFORMATION

| **Name** (FIRST MI LAST) | **Employee ID** | **Date of Birth** (MM/DD/YYYY) |
|---|---|---|
| | | |

**Date of Hire** (MM/DD/YYYY)

**Group Policy Number**
S05630

## DEPENDENT INFORMATION (ADDITIONAL CHILDREN MAY BE LISTED ON SEPARATE PAPER AND ATTACHED TO/SUBMITTED WITH THIS FORM)

| **Spouse Name** (FIRST MI LAST) ☐ N/A | **Date of Birth** | **Gender** ☐ M ☐ F | **Date Married** |
|---|---|---|---|
| | | | |

| **Child Name** (FIRST MI LAST) | **Date of Birth** | **Gender** | **Child Name** (FIRST MI LAST) | **Date of Birth** | **Gender** |
|---|---|---|---|---|---|
| | | ☐ M ☐ F | | | ☐ M ☐ F |
| | | ☐ M ☐ F | | | ☐ M ☐ F |

## VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

| **Coverage Tier – Select One Option** | | **Employee Benefit Amount – Select One Option** | **Bi-weekly Premium Amount** (Cost per Pay Period – 26/Year) | |
|---|---|---|---|---|
| | | | **EE Only** | **Family** |
| ☐ Employee Only (EE Only) | ☐ Employee & Family (Family) | ☐ $5,000 | $_____ | $_____ |
| | | ☐ $10,000 | $_____ | $_____ |
| | | ☐ $15,000 | $_____ | $_____ |
| | | ☐ $500,000 | $_____ | $_____ |
| | | ☐ $_____ | $_____ | $_____ |
| ☐ Decline Coverage | | N/A | N/A | |

**Additional Information:**
- The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 70.

## BENEFICIARY DESIGNATION (PLEASE ENSURE YOUR BENEFICIARY DESIGNATION IS CLEAR SO THERE IS NO QUESTION OF YOUR INTENT)

This designation is for **all** group insurance coverage issued by The Hartford for which benefits are payable to a beneficiary or survivor (as indicated by each specific policy) in the event of your death, unless otherwise requested by you in writing. This designation may be changed upon written request. **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 a separate paper and attach it to/submit it with this form, clearly stating your name. Please consult your benefits administrator or legal advisor for assistance or additional information.

Certain states are community property states. If you live in one of these states – AK, AR, CA, HI, 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. Spousal consent may not apply to ERISA plans. Please consult your benefits administrator or 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 acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.
- I understand and agree that: 1) If I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective; 2) My request for coverage may be denied by The Hartford; 3) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) Only the insurance policy(ies) issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy; 6) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 7) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.
- I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy, and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.
- I have read and understand the "Important Notice – Fraud Warning Statements" that applies to my state of residence.

| **Employee Signature** | **Date of Signature** |
|---|---|
| | |

**END OF FORM – PLEASE REVIEW THE "IMPORTANT NOTICE – FRAUD WARNING STATEMENTS" ON THE FOLLOWING PAGE**

# Benefits Enrollment Form
# Important Notice – Fraud Warning Statements
# Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

THE HARTFORD

**Please read the statement that applies to your state of residence prior to signing the enrollment form.**

**For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington:** 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 Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**For Residents of California:** The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

**For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**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 a statement of claim or 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 Maine, Tennessee, Virginia and 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 may include imprisonment, fines and denial of insurance benefits.

**For residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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 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 New Mexico and North Carolina:** 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 submit to civil fines and criminal penalties.

**For residents of New York (not applicable to Life Insurance):** 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 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 Oregon:** 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

**For residents of Pennsylvania:** 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For residents of Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**For residents of Virginia:** Any person who, with the 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 may have violated the state law.