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

INSURED INFORMATION

Primary Insured Name* (FIRST MI LAST)		Group/Employer Name	
Firefighter First, Middle, Last name		Georgia Municipal Association / EMPLOYER CITY NAME	
Policy Number(s)	**CI:** 681159	**ACC:**	**HI:**

STEP 1: OBTAIN CURRENT 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 the policyholder's/your former employer's plan.

Please enter below the Coverage Tier that you were insured for under the policyholder's/former employer's plan and the amount of monthly premium being paid. The Coverage Tier is defined as Employee, Employee + Spouse, Employee + Child(ren), or Family.

Current Coverage & Premium Information

Coverage Type	Coverage Tier	Coverage Amount	Current Monthly Premium
Accident (AI)		N/A	
Critical Illness/Specified Disease (CI)	Employee	$25,000	$9.12
Hospital Indemnity (HI)		N/A	

STEP 2: INITIAL PREMIUM PAYMENT CALCULATION

Please complete each line below as instructed for each coverage type that you were insured for under the policyholder's/former employer plan.

	AI	CI	HI
(1) Enter the Current Monthly Premium shown above for each Coverage Type available to you:		$9.12	
(2) The initial first quarter premium is required. (You may select your future Billing Mode later on page 5)		3	
(3) Multiply the monthly amount for each coverage in line 1 by the billing multiplier in line 2 to calculate the initial premium due for each Coverage Type.		$27.36	
(4) Add the amounts across on line 3 together (if requesting multiple coverages) or reenter the amount from line 3 (if electing only 1 coverage) for the **Total Initial Premium Due.**		$27.36	

PREMIUM REMITTANCE FORM SUBMISSION

Enter the Total Initial Premium Due from line 4 above onto the remittance form on Page 5.

Extended Continuation Beneficiary Designation for Accident and/or Hospital Indemnity Insurance

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The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

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INSURED INFORMATION

Primary Insured Name* (FIRST MI LAST)	Last 4 of SSN/Tax ID*	Group/Employer Name
Firefighter First, Middle, Last Name	Last 4 of SSN	Georgia Municipal Association / CITY EMPLOYER NAME
Policy Number(s) 681160	**ACC:**	**HI:**

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 and/or hospital indemnity insurance, which are due and unpaid at the time of your (the primary insured's) death. 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.

Please complete Primary Beneficiary portion as applicable. Examples of beneficiaries would be a spouse or child.

erty states. If you live in one of these states – AK, AR, CA, ID, LA, NV, NM, TX, WA or WI – and r spouse as your beneficiary, state law may require that your spouse consent to the designation. lictions 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	Please sign and date.	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 should mail it with your premium remittance form and payment.
2) Mail the form to: The Hartford Portability & Conversion Unit
   PO Box 43786 — Fax 1-440-646-9339
   Cleveland OH 44143-0786 — https://info.selmanco.com/hartfordnocp
3) Keep a copy of the completed form for your records.

Extended Continuation Premium Remittance Form for Accident, Critical Illness/ Specified Disease and/or Hospital Indemnity Insurance

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

Please complete the Insured Information and Address for Future Billing portions in their entirety below.

ut · Phone: 877-320-0484
ancial Services Group, Inc., and its subsidiaries.

Extended Continuation Premium Remittance Form (REQUIRED FIELDS ARE MARKED WITH AN ASTERISK (*))

Insured Information

Primary Insured Name* (FIRST MI LAST)	**Gender*** ☐ M ☐ F	**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 POLICY)

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

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
		☐ M ☐ F			☐ M ☐ F

Coverage Request & Premium Due

Coverage Type*	**Coverage Tier***	**Coverage Amount***	**Future Billing Mode – Select One***	**Future Billing Option – Select One***	**Total Initial Premium Due* (amount from page 3)**
☐ Accident		N/A	☐ Quarterly ☐ Semi-Annual ☐ Annual	☐ Direct Billed ☐ Electronic Funds Transfer (EFT) (Please complete the separate EFT form)	Based on the billing frequency you select, please enter the appropriate premium based on a charge of $9.12 / month.
☒ Critical Illness	Employee	$25,000			
☐ Hospital Indemnity		N/A			

Please select one option above.

STEP 3: PREMIUM REMITTANCE FORM SUBMISSION

1) Select the ongoing Billing Mode above that you prefer by checking the box for one billing mode option. If you select Quarterly, you will receive a bill every 3 months on an ongoing basis. If you select Semi-Annual, you will receive a bill every 6 months on an ongoing basis. If you select Annual, you will receive a bill every 12 months on an ongoing basis.
2) Make your check or money order for the total due payable to "**The Hartford**." Be sure to include the Primary Insured's name on the payment.
3) Mail your payment with the completed request form, remittance form and beneficiary designation form (if HI/ACC elected) to The Hartford as soon as possible (no more than 91 days) after insurance would otherwise end under the policyholder's/your former employer's plan.
4) Mail all forms and payment to: The Hartford Portability & Conversion Unit
   PO Box 43786 Fax 1-440-646-9339
   Cleveland OH 44143-0786 https://info.selmanco.com/hartfordnocp

Primary Insured Signature	**Date of Signature**

Please sign and date above. Please mail a check for the premium and this completed form to Hartford at the address outlined in Step 3.