
# Town of Carlisle

# Basic/Supplemental Life Insurance Program

Minimum eligibility requirement is 20 hours/week (50% of a full time job)

## Basic Life/ AD&D Insurance Plan

- $5,000
- Employee contribution 50% - $2.04/month

## Supplemental Life/AD&D Insurance Plan

- Employee must enroll in Basic Life to enroll in the Supplemental Life/ AD&D
- Approximately one times annual salary.
- Maximum $70,000.
- 100% paid by the employee.
- No evidence of insurability required during open enrollment.
- Portability of Life to an individual policy upon loss of coverage.
- Accidental death pays twice the chosen benefit (included in rate).
- Purchased in units of $5,000 (up to the maximum of l x salary rounded down to nearest $5,000).
- Cost per $5,000 /month = $4.85.
- Spousal benefit can be purchased in units of $5,000 (up to a maximum of $50,000 and no more than 50% of the employee's elected supplemental coverage, Employee must be enrolled in supplemental coverage in order for spouse to apply).
- Cost per $5,000 /month = $4.20
- $2,000 of coverage available to dependent children - cost is .16¢ per month

**Employee Supplemental Insurance Rates:**

| Benefit | Cost/Month |
|---|---|
| $5,000 | $4.85 |
| $10,000 | $9.70 |
| $15,000 | $14.55 |
| $20,000 | $19.40 |
| $25,000 | $24.25 |
| $30,000 | $29.10 |
| $35,000 | $33.95 |
| $40,000 | $38.80 |
| $45,000 | $43.65 |
| $50,000 | $48.50 |
| $55,000 | $53.35 |
| $60,000 | $58.20 |
| $65,000 | $63.05 |
| $70,000 | $67.90 |

# BASIC and SUPPLEMENTAL GROUP TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

## Town of Carlisle

The group term Life and Accidental Death and Dismemberment (AD&D) insurance available through your employer is a smart, affordable way to purchase the extra protection that you and your family may need. Life and AD&D insurance offers financial protection by providing you coverage in case of an untimely death or an accident that destroys your income-earning ability. Life benefits are disbursed to your beneficiaries in a lump sum in the event of your death.

Approximately 50 million households recognize they need more life insurance (40 percent of households).[1]

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

## COVERAGE INFORMATION

| APPLICANT | BASIC COVERAGE | SUPPLEMENTAL COVERAGE |
|---|---|---|
| **Employee** | Benefit[2]: $5,000<br>AD&D: Included | Benefit: Increments of $5,000<br>Maximum: the lesser of 3x earnings or $70,000<br>AD&D: Included |
| **Spouse** | Not Included | Benefit : Increments of $5,000<br>Maximum: the lesser of 50% of your supplemental coverage or $35,000<br>AD&D: Not Included |
| **Child(ren)** | Not Included | Benefit: $2,000<br>AD&D: Not Included |

**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 | BASIC COVERAGE | SUPPLEMENTAL COVERAGE |
|---|---|---|
| Life | 100% | 100% |
| Both Hands or Both Feet or Sight of Both Eyes | 100% | 100% |
| One Hand and One Foot | 100% | 100% |
| Speech and Hearing in Both Ears | 100% | 100% |
| Either Hand or Foot and Sight of One Eye | 100% | 100% |
| Movement of Both Upper and Lower Limbs (Quadriplegia) | 100% | 100% |
| Movement of Both Lower Limbs (Paraplegia) | 75% | 75% |
| Movement of Three Limbs (Triplegia) | 75% | 75% |
| Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia) | 50% | 50% |
| Either Hand or Foot | 50% | 50% |
| Sight of One Eye | 50% | 50% |
| Speech or Hearing in Both Ears | 50% | 50% |
| Movement of One Limb (Uniplegia) | 25% | 25% |

| | | |
|---|---|---|
| Thumb and Index Finger of Either Hand | 25% | 25% |

## PREMIUMS

Your employer pays for a portion of the premium for this coverage. Your contribution is shown on the Premium Worksheet.[3]

## ASKED & ANSWERED

### WHO IS ELIGIBLE?

You are eligible if you are an active full time employee who works at least 20 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 19 (or under age 23 if a full-time student).

### AM I GUARANTEED COVERAGE?

For basic coverage, if your coverage amount exceeds , you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of 3 times your annual earnings, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of $5,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your spouse's current coverage, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

Supplemental insurance is guaranteed issue coverage – it is available without having to provide information about your child(ren)'s health.

AD&D is available without having to provide information about your health.

### HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Your employer pays 50 of the premium for your Employee basic coverage.

Premiums for supplemental coverage are provided on the Premium Worksheet. You have a choice of coverage amounts. You may elect supplemental insurance for you only, or for you and your dependent(s).

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 a payment.

### WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, or within 31 days of the date you have a change in family status, .

### WHEN DOES THIS INSURANCE BEGIN?

Insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

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, 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 life coverage with you. Coverage may be continued for you and your dependent(s) under a group portability certificate or an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion and portability are described in the certificate. Conversion and portability are not available for AD&D coverage.

[1]LIMRA, Facts About Life 2016. Web. 30 June 2017. <https://www.limra.com/uploadedFiles/limra.com/LIMRA_Root/Posts/PR/_Media/PDFs/Facts-of-Life-2016.pdf>
[3]Rates and/or benefits may be changed.

# 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 LIFE INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- A benefit will not be paid if death occurs by suicide within two years (or as allowed by state law) of purchasing this coverage.
- 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 dependents 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.
- Coverage may not be elected for a dependent who is in active full-time military service.
- Child(ren) may only be covered as a dependent of one employee.
- Infants may receive a reduced benefit prior to the age of six months.



## GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- 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 must be a citizen or legal resident of the United States, its territories and protectorates.

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 have coverage.



## GROUP LONG TERM DISABILITY INSURANCE

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS

- You must be under the regular care of a physician to receive benefits.
- You cannot receive disability insurance benefit payments for disabilities that are caused or contributed to by:
  - War or act of war (declared or not)
  - The commission of, or attempt to commit a felony
  - An intentionally self-inflicted injury
  - Your being engaged in an illegal occupation

PRE-EXISTING CONDITIONS

- Your insurance excludes the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your certificate, you will be covered for a disability due to that condition only if:
  - You have not received treatment for your condition for 6 months before the effective date of your insurance, or
  - You have not received treatment for your condition for 6 months after the effective date of your insurance, or
  - You have been insured under this coverage for 12 months prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
  - You have already satisfied the pre-existing condition requirement of your previous insurer

LIMITATIONS

- **Mental Illness Limitation.** If you are disabled because of Mental Illness, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.
- **Substance Abuse Limitation.** If you are disabled because of alcoholism or use of narcotics, sedatives, stimulants, hallucinogens or other similar substance, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.

OFFSETS

- Your benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:
  - Social Security disability insurance (please see next section for exceptions)
  - Workers' compensation
  - Other employer-based insurance coverage you may have
  - Unemployment benefits
  - Settlements or judgments for income loss
  - Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Your benefit payments will not be reduced by certain kinds of other income, such as:
  - Retirement benefits if you were already receiving them before you became disabled
  - Retirement benefits that are funded by your after-tax contributions your personal savings, investments, IRAs or Keoghs profit-sharing
  - Most personal disability policies
  - Social Security cost-of-living increases

This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the Policy:

Insured's monthly [Pre-Disability Earnings/Basic Monthly Pay] $3,000
Long term disability benefits percentage x 60%
Unreduced maximum benefit $1,800
Less Social Security disability benefit per month - $900

Less state disability income benefit per month - $300
Total amount of long term disability benefit per month $600

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.



**Prepare. Protect. Prevail. With The Hartford.®**
The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT.

This Benefit Highlights document explains the general purpose of the insurance 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.

Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza, Hartford, CT 06155

(A stock insurance company)


## Town of Carlisle

## Benefits Enrollment Form

- All Employees must update Beneficiaries as needed.

## Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter and/or check** your coverage elections. Make sure the coverage amount that you elect includes your existing coverage amount. You may only elect and will be covered for levels of coverage included in your employer's contract.
- **Step 2:** Please **sign, date and return** this form to Human Resources. Do not mail this form back to The Hartford's address indicated at the top of this form.

| **Information About You** | | | |
|---|---|---|---|
| **Employee Name:** | **Employee ID (if not available, then Social Security Number):** | | |
| **Address:** | **City:** | **State:** | **Zip Code:** |
| **Date of Birth:** | | | |
| **Date of Hire:** | | | |
| **Department:** | | | |


Form PA-9604

Town of Carlisle

Prepare today.
Help protect tomorrow.

60683-

Name: _____

| Dependent Information | | | | | If more than 4 child(ren), attach additional sheet. |
|---|---|---|---|---|---|
| Spouse Name: | | Gender: | Spouse Date of Birth: | Date of Marriage: | |
| | | ☐ M ☐ F | | | |
| Child Name: | Gender: | Date of Birth: | Child Name: | Gender: | Date of Birth: |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |

## Basic Life and AD&D Insurance

If coverage amounts are based on earnings, your cost may change if your earnings change.

Amount of Life/AD&D: $5,000

☐ I elect to **purchase** $5,000 of life and AD&D
☐ I **decline** to purchase life and AD&D coverage.

## Supplemental Life and AD&D Insurance

Employee Maximum: $70,000

*$5,000 Units to a Maximum of 1x Salary

☐ I elect to **purchase** $ _____ of life coverage.
☐ I **decline** to purchase life coverage.

## Spouse Supplemental Life Insurance

Spouse Life insurance is: $50,000 in $5,000 increments
☐ I elect to **purchase** $ _____ Of dependent life coverage.
☐ I **decline** to purchase life coverage.

## Child(ren) Supplemental Life Insurance

Child Coverage is: $2,000
*15 days to 6 months - $400 ; 6 months to 19 - $2,000

☐ I elect to **purchase** $2,000 of life coverage.
☐ I **decline** to purchase life coverage.

Name: _____

## Beneficiary Designation

You must select your beneficiary – 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.

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. Please provide **all** of the information requested below. 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 benefits administrator or your own legal advisor.

This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you. A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time you die.

**PRIMARY BENEFICIARY**

| | | | | |
|---|---|---|---|---|
| **Primary Beneficiary Name:** | **Social Security #:** | **Date of Birth:** | **Relationship:** | **Percentage:** |
| **Address:** | | | **Phone Number:** | |
| **Primary Beneficiary Name:** | **Social Security #:** | **Date of Birth:** | **Relationship:** | **Percentage:** |
| **Address:** | | | **Phone Number:** | |

**CONTINGENT BENEFICIARY**

| | | | | |
|---|---|---|---|---|
| **Contingent Beneficiary Name:** | **Social Security #:** | **Date of Birth:** | **Relationship:** | **Percentage:** |
| **Address:** | | | **Phone Number:** | |
| **Contingent Beneficiary Name:** | **Social Security #:** | **Date of Birth:** | **Relationship:** | **Percentage:** |
| **Address:** | | | **Phone Number:** | |

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

Consent For Community Property States Only: If you live in a community property state – **Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin** – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. **Disclaimer:** Spousal consent does not apply to ERISA plans. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will represent that, as spouse of the employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ Date: _____

**Name:** _____

Confirmation:

I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that 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. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit(s) reduce at a specified age(s) stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand rates and benefits may be changed by the insurer.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force.

**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 Louisiana and Maryland:**

Any person who knowingly (knowingly or willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly or willfully in Maryland) 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 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 Virginia:**

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.

Signed _____ Date _____