GROUP VOLUNTARY LONG-TERM DISABILITY INSURANCE BENEFIT HIGHLIGHTS

Just over 1 in 4 of today's 20 year-olds will become disabled before they retire (age 67).[1]

FLORIDA DEPARTMENT OF TRANSPORTATION

A disability can happen to anyone. Long-term disability insurance helps protect your paycheck if you're unable to work for a long period of time after a serious condition, injury or sickness.

To learn more about Long-Term Disability insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION

COVERAGE LEVEL	BENEFIT PERCENTAGE (PERCENT OF YOUR EARNINGS)	MAXIMUM	MINIMUM (BASED ON MONTHLY INCOME LOSS BEFORE THE DEDUCTION OF OTHER INCOME BENEFITS)	BENEFIT STARTS (ELIMINATION PERIOD)	BENEFIT DURATION
Option 1	60%	$5,000	$100	After 3 months disabled	Disabled before: Age 62 Benefit duration: As long as you are disabled Benefit duration maximum: Age 65
Option 2	60%	$5,000	$100	After 6 months disabled	Disabled before: Age 62 Benefit duration: As long as you are disabled Benefit duration maximum: Age 65
Option 3	60%	$5,000	$100	After 12 months disabled	Disabled before: Age 62 Benefit duration: As long as you are disabled Benefit duration maximum: Age 65

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 who works at least 30 hours per week on a regularly scheduled basis or an active full-time shared employment employee who works at least 20 hours per week on a regularly scheduled basis.

AM I GUARANTEED COVERAGE?

If this is the first time you are eligible to elect coverage, evidence of insurability is not required.

If you did not elect coverage the first time it was offered to you, evidence of insurability is required to elect coverage. Evidence of insurability is also required to make a change to enhance your current coverage.

This coverage is subject to a pre-existing condition exclusion, which is detailed on the Limitations & Exclusions sheet.[3]

HOW DO I PAY FOR THIS INSURANCE?

Premium 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, within 31 days of the date you have a change in family status, or within 60 days of the completion of any eligibility waiting period established by your employer.

WHEN DOES THIS INSURANCE BEGIN?

The initial effective date of this coverage is January 1, 2020. Subject to any eligibility waiting period established by your employer, if you enroll for coverage prior to this date, insurance will become effective on this date. If you enroll for coverage after this date, 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.

WHEN DOES THIS INSURANCE END?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you leave your employer, or the coverage is no longer offered.

WHAT DOES IT MEAN TO BE DISABLED?

Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are less than 80% of your pre-disability earnings. Once you have been disabled for 3 years following the elimination period, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are less than or equal to 60% of your pre-disability earnings.

Pre-disability earnings are defined in your policy.

[1]U.S. Social Security Administration Fact Sheet. Web. 30 June 2017 https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf

[2]Rates and/or benefits may be changed. Rates are based on the age of the insured person and increase on the policy anniversary date on or following your birthday as you enter each new age category.

[3]The Long Term Disability policy contains a Pre-Existing Condition Exclusion. Please refer to the certificate for more information on exclusions and limitations, such as Pre-Existing Conditions.

Prepare. Protect. Prevail. With The Hartford.®

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.

GROUP LONG TERM DISABILITY INSURANCE

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 and Substance Abuse Limitation**. If you are disabled because of Mental Illness or because of alcoholism or the 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.

PREMIUM WORKSHEET

Rates and/or benefits can change.

VOLUNTARY LONG TERM DISABILITY INSURANCE

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

Premiums are based on the employee's current age and increase as the employee enters each new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Option 1 Rates	$0.2538	$0.2538	$0.2538	$0.2538	$0.3785	$0.3785	$0.5077	$0.5077	$0.5077	$0.5077	$0.5077	$0.5077
Option 2 Rates	$0.2123	$0.2123	$0.2123	$0.2123	$0.3185	$0.3185	$0.4246	$0.4246	$0.4246	$0.4246	$0.4246	$0.4246
Option 3 Rates	$0.1846	$0.1846	$0.1846	$0.1846	$0.2723	$0.2723	$0.3646	$0.3646	$0.3646	$0.3646	$0.3646	$0.3646

To calculate your bi-weekly premium amount, use the following formula.

_____	÷ 12 =	_____	÷ 100 =	_____	x	_____	=	_____
Your Annual Earnings Maximum = $100,00		Your Monthly Earnings				Rate		Premium Amount

Prepare. Protect. Prevail. With The Hartford.®

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 by the enrollment deadline. (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** 024614	

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 LONG TERM DISABILITY INSURANCE

Coverage for Employee Only	**Elimination Period**	**Bi-Weekly Premium Amount** (Cost per Pay Period – 26/Year)	**Elect Coverage**	**Decline Coverage**
Option 1	3 months	$_____ (Requires EOI*)	☐	☐
Option 2	6 months	$_____ (Requires EOI*)	☐	☐
Option 3	12 months	$_____ (Requires EOI*)	☐	☐

Additional Information:

- Your benefit amount is based on your earnings; therefore, your benefit and premium amount will change as your earnings change.
- Your premium amount is based on your age; therefore, your premium amount will change, as you grow older.
- *If you were previously eligible for coverage and are enrolling for the first time or for an increase in coverage, you must complete and submit an evidence of insurability (EOI) form/health application. The form is available from your employer. However, if you are enrolling for an increase in coverage to a higher option that your employer is offering for the first time, no EOI form/health application will be required.

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)	☐ $10,000	Paid by Employer	Paid by Employer
		☐ $15,000	Paid by Employer	Paid by Employer
		☐ $20,000	Paid by Employer	Paid by Employer
		☐ $25,000	Paid by Employer	Paid by Employer
		☐ $_____	Paid by Employer	Paid by Employer
☐ 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.

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 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 subject 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.