

**CITY OF VENICE
ENROLLMENT FORM**

Information About You

Name:	Social Security Number / Employee ID Number:
Date of Birth:	Date of Hire:

Instructions

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

- **Step 1:** Please enter or check your coverage elections and details. *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.

The following costs should be calculated based on your salary as of the effective date.

Long Term Disability (LTD) Buy-Up Insurance

LTD insurance helps replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as an elimination period, of 90 days. City of Venice's plan provides you with income protection to replace up to 40% of your regular pay to a maximum monthly benefit of \$5,000.

You have the opportunity to increase this coverage and have income protection to replace up to 60% of your regular pay to a maximum monthly benefit of \$5,000 by enrolling in City of Venice's LTD Buy-Up plan.

Use the calculation line below to determine your Bi-weekly (26) cost for this coverage.*

I elect to **enroll** in the Voluntary LTD Buy-Up plan at the Bi-weekly (26) cost below.*

$$\begin{array}{ccccccc}
 \underline{\hspace{2cm}} & \div 12 = & \underline{\hspace{2cm}} & \div 100 = & \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & = & \underline{\hspace{2cm}} & \times 12 \div 26 = & \$ & \underline{\hspace{2cm}} \\
 \text{Annual Salary} & & \text{Monthly} & & & \times & \text{.685} & & & & & \text{Your Bi-weekly (26)} \\
 \text{Maximum = \$100,000} & & \text{Salary} & & & & \text{Rate} & & & & & \text{Cost*}
 \end{array}$$

I elect to **decline** the Voluntary LTD Buy-Up plan.

*Your cost may change if your salary changes within the benefits plan year.

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Employee Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage described in the Benefit Highlight Sheets and offered through City of Venice.

I understand and agree that if I decline coverage now, but later decide to enroll, I will 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 the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your 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 is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

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 not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____

Date _____