FOR MEMBERS OF THE THE ARC

The Arc
For people with intellectual and developmental disabilities

TERM LIFE INSURANCE PLAN ENROLLMENT FORM

TO ENROLL:
Send this completed form to:
ADMINISTRATOR
The Arc GROUP INSURANCE PROGRAM
P.O. Box 10374
Des Moines, IA 50306-8812

QUESTIONS?
Call: 1-800-503-9230
E-Mail: customerservice.service@mercer.com

THE HARTFORD
Underwritten by:
Hartford Life and Accident Insurance Company
Hartford, CT 06155

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Member Information

Phone Numbers:

Home _____

Work _____

E-Mail Address _____

Date of Birth _____
(MM/DD/YYYY)

Place of Birth (City, State) _____

(Country) _____

Height _____ft. _____in. Weight _____lbs. Sex ❑ M ❑ F

Name of Beneficiary _____

Relationship of Beneficiary _____

I would like to contribute part of the life benefit to The Arc by designating $_____ of my life benefit to The Arc as a beneficiary.

Check the amount of coverage you are enrolling for:

❑ $10,000 ❑ $5,000

Check the billing option you want:

❑ Automatic Monthly Check Withdrawal ❑ Semi-Annual Direct Bill
(If you select Automatic Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

BE SURE TO COMPLETE ALL PAGES AND SIGN LAST PAGE ➡

I understand and agree that during the first 2 1/2 years, only death resulting from injury is covered (death from suicide or self-inflicted injuries is not covered for 2 years). In the case of death from sickness in the first 2 1/2 years, benefits are limited to the return of all premiums paid.
I understand and agree that if I am hospitalized, live in an institution or am disabled due to an injury or sickness (but not because of an intellectual and developmental disability), my coverage will be postponed until the first of the month following the date I am no longer hospitalized, live in an institution or am disabled due to an accident or sickness.

Signature of Applicant X_____Date _____

OR

Signature of Parent or Guardian X_____Date _____

Relationship to the Proposed Insured_____

Name of Local Chapter of The Arc_____

I am now a paid member of The Arc and have been since_____

By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? ❑ Yes ❑ No

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

Life Form Series includes GBD-1000, GBD-1100, or state equivalent.
Policy # AGL-1935
LI648E-AGL1935
7/20

AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ Date: _____

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The Arc's Life Insurance Plan

For Members of The Arc

$5,000 or $10,000 of Group Term Life Insurance with Guaranteed Acceptance

No health questions...no physical exam.

Choose $5,000 or $10,000 of group term life insurance.

As long as the member meets the requirements as described in this brochure, acceptance is guaranteed.

Term Life Group Rates

Affordable group insurance rates have been made possible as a result of The Arc and the Insurance Administrator negotiating with the underwriter. Use this Plan to complement other coverage or to secure a "starter" policy.

Conversion Privilege

You may convert your group term life insurance into an individual insurance policy, subject to the policy provisions offered by the insurance company if coverage ends for any reason except nonpayment of premiums. You will not be required to provide any physical proof of insurability for this conversion to an individual life insurance policy. Your Certificate of Insurance contains more details on this conversion privilege.

Your Choice of Beneficiary

Choose anyone you wish to be your beneficiary. This is a unique opportunity for you to remember The Arc in your estate planning. You may change your beneficiary at any time by writing to the Insurance Administrator. Claim payments for this Plan are made promptly upon satisfactory proof of death. If you do not name a beneficiary or if no named beneficiary survives you, we may pay in order: the executors or administrators of your estate, all to your surviving spouse, if your spouse does not survive you, in equal shares to your surviving children; or if no child survives you, in equal shares to your surviving parents.

Renewable to Age 80

You may continue your coverage all the way to age 80, assuming you pay your premiums when due, you remain an active member of The Arc and the Master Policy remains in force.

A Service to Our Members

This program has been designed for members of The Arc, including people with an intellectual and developmental disability.

This coverage is available only for residents of the United States excluding ID, MN, MT, OR, NH, WA and HI.

Exclusion for Suicide

Death resulting from suicide while sane or insane in the first two years of coverage will pay the amount of premiums paid up to the date of death or two years following an increase in coverage (amount of Insurance payable will equal the amount of insurance in force prior to the increase plus an amount equal to the premium paid for the increase to the date of death).

Limitation for Death Due to Non-Injury Causes

During the first two and half years, only death from injury is covered. In the case of death from a sickness that occurs during the first two and a half years of coverage, the amount payable will be equal to the premiums paid for coverage, with interest using an annual interest rate of 1% compound monthly. After the first two and a half years, the face amount will be payable for death due to Accidental Injury or Sickness.

Convenient Payment Options

Choose between two premium payment options, whichever one best suits your needs.

Option 1: Pay through automatic monthly check withdrawal. This saves you the time spent writing checks and remembering due dates.

Option 2: Pay through direct billing on a semiannual basis.

Affordable Monthly Premiums		
Age of Insured	*$5,000*	*$10,000*
2–19	$11.21	$22.41
20–24	12.58	25.16
25–29	13.13	26.26
30–34	13.96	27.91
35–39	14.85	29.70
40–44	16.23	32.45
45–49	16.50	33.00
50–54	30.94	61.88
55–59	44.69	89.38
60–64*	61.88	123.75
65–69*	110.00	220.00
70–74*	144.38	288.75
75–79*	192.50	385.00

*For renewal purposes only. A person cannot apply at age 60 or over. Coverage can be provided to age 80.

Rates are based on the attained age of the Insured person and increase as you enter each new age category.

All changes in premiums and coverages are made at the premium due date coinciding with or next following the insured's attained age.

This table should not be used to calculate your premium beyond your attained age when coverage becomes effective.

Rates and/or benefits may be changed on a class basis.

How to compute your premium if paying through semi-annual direct bill: find the monthly premium above that matches your age group and the coverage amount you want, multiply by six. Example: You are 38 years old and are applying for $10,000 in coverage. $29.70 x 6 = $178.20.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

Satisfaction Guaranteed

If you are not completely satisfied with the terms of your coverage after you receive your Certificate of Insurance, return it within 30 days. Your money will be refunded in full, minus any claims paid, for any reason! No questions asked!

Here's How to Enroll

1. Complete, date and sign the Enrollment Form enclosed; be sure to indicate the amount of coverage you are enrolling for.
2. Indicate your billing preference. If you are paying through automatic monthly check withdrawal, you must also include a check for your first monthly premium and a blank voided check or deposit slip.

   If you select semi-annual direct bill, just include a check.
3. Mail your check (and a blank voided check or deposit slip if applicable) and Enrollment Form to:

   Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
   P.O. Box 10374
   Des Moines, IA 50306-8812
   1-800-503-9230

Effective Date

Coverage will become effective the first of the month following receipt of your completed enrollment form and payment of the required premium.

Who May Enroll

We are offering you an opportunity to participate in the Hartford Life and Accident Insurance Company Term Life Insurance Plan. This valuable coverage is designed for members of The Arc with an intellectual and developmental disability. This benefit represents our continuing effort to provide broader and more beneficial assistance for members of The Arc. As long as you are under age 60, are a citizen or legal resident of the United States, are not hospitalized, do not live in an Institution or are not disabled due to an Injury or Sickness (excludes intellectual and developmental disability), acceptance is guaranteed.

This insurance should not replace any life insurance you currently have.

A Mem**bership Service of:**

The Arc
For people with intellectual and developmental disabilities

Administered By:

Mercer

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
P.O. Box 10374
Des Moines, IA 50306-8812

Questions?
1-800-503-9230
www.thearcinsurance.com

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

Underwritten By:

THE HARTFORD

Hartford Life and Accident Insurance Company
Hartford, CT 06155

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

This brochure 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 brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Hartford Life and Accident Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder.

Since coverage is issued without medical underwriting, the premium rate being charged includes an extra mortality risk charge.

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Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

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HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK

IMPORTANT REPLACEMENT NOTICE

THIS NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY INSURANCE REGULATION NO. 60

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into a paid-up or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to contemplating a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you to decide whether the replacement is in your best interest.

I HAVE READ THE IMPORTANT REPLACEMENT NOTICE THAT ACCOMPANIED THIS APPLICATION.

Do you intend to replace, in whole or in part, any existing life insurance or annuity?
Yes_____No_____

Date: _____Signature of Applicant: _____

Date: _____Signature of Applicant: _____

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BENEFICIARY DESIGNATION FORM INSTRUCTIONS

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 plan. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group.

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. The listed percentages must add up to 100%. Please provide all of the information requested. 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 the company's representative or your own legal advisor.

A beneficiary designation may be changed at any time upon written request.

Please note that a Power of Attorney (POA) may not have the authority to change a beneficiary.

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Doe	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Insured/Member) and dated.**

BENEFICIARY DESIGNATION

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designations(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group and direct that the insurance proceeds payable under the policy be paid as indicated below.

Insured/Member Name:	Date of Birth:	Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐
Insured/Member Address:		Telephone Number: ( )
Policyholder:		Policy Number:

NAMING YOUR LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact the company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, according to the terms under the policy.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state – Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Teas, Washington, or 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. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse fo the Insured named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of the group life term and/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 Insured/Member's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Insured/Member: _____ **Date:** _____

Please note that a Power of Attorney (POA) may not have the authority to change a beneficiary.