ENROLLMENT FORM FOR GROUP INSURANCE

Group ID:	Group Policy #:	**Please Select Billing Location**
City of Pine Bluff	**GLT 892730**	**015964890002 – COPB** **015964890001 – Wastewater**

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name	County	Employer ZIP	State
City of Pine Bluff	**Jefferson**	**71601**	**AR**

Employee First Name / Middle Initial / Last Name	Social Security Number	Date of Birth

Street Address / City / State / Zip

Gender:	Marital Status:	Home Phone	Work Phone

Employee Work Information (Complete for ALL Enrollments)

Average Work Week:	Occupation:	Earnings:	Date Of Full-Time Employment:	Rehire Date:

Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for all coverages you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Premium

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Type of Coverage	Selecting yes authorizes my employer to payroll deduct premium(s)	Amount of Coverage	Monthly Deduction
Short Term Disability Provided By: The Hartford	☐**Yes** ☐**No***		
Long Term Disability Provided By: The Hartford	☐**Yes** ☐**No***		

*By selecting no, application for coverage at a later date may require further medical information and/or physical exam, which will be at my own expense. Actual deductions may vary slightly from above illustration due to rounding

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.

Signature Section:

I acknowledge I have received and reviewed enrollment materials explaining the benefits offered and the exclusions, limitations and reductions that apply. I understand that the effective date of coverage will vary based on contract terms. I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that the elections I have made will remain in effect for the entire Plan year and may be changed only at the annual enrollment period or within 31 days of a qualifying event or change in family status.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above.

Employee Full Name:

Employee Signature: _____ Date:_____

Premium Worksheet

Rates and/or benefits can change. Rates are based on the employee's age and increase as you enter each new age category.

VOLUNTARY SHORT TERM DISABILITY INSURANCE

Monthly Premium Amount (Cost per Pay Period – 12/Year)

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rates	$0.5140	$0.5630	$0.5040	$0.4950	$0.5340	$0.5630	$0.6700	$0.8450	$1.0290	$1.1460	$1.1460	$1.1460

To calculate your monthly premium amount, use the following formula.

_____	÷ 52 =	_____	x 60% =	_____	÷ 10 =	_____	x	_____	=	_____	
Your Annual Earnings		Your Weekly Earnings		Weekly Benefit Max = $500				Rate		Premium Amount	

VOLUNTARY LONG TERM DISABILITY INSURANCE

Monthly Premium Amount (Cost per Pay Period – 12/Year)

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rates	$0.2610	$0.2610	$0.4770	$0.6750	$0.8640	$1.1880	$1.5840	$2.0070	$2.0430	$2.6550	$2.6550	$2.6550

To calculate your monthly premium amount, use the following formula.

_____	÷ 12 =	_____	÷ 100 =	_____	x	_____	=	_____	
Your Annual Earnings Maximum = $100,000		Your Monthly Earnings				Rate		Premium Amount	

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CREATION DATE: 12/3/2020
CITY OF PINE BLUFF/00119281