Long-Term/Short-Term Disability Enrollment Form

EXCLUSIVELY FOR EMPLOYEES OF UCONN

THE HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Social Security Number	Name (first, middle initial, last name)		
Home Address Street	City	State	Zip Code
Date of Birth	Job Position/Department		
Email Address (If you would like a confirmation of your application being received)			

The Hartford's voluntary disability plan has two parts. The first part is a short-term disability plan that will pay weekly benefits after you have been disabled for 30, 60, or 120 days (depending on the plan you choose). The short-term part of your disability plan will pay weekly benefits until you have been disabled for a total of six months. Then the long-term disability plan will automatically pay you monthly benefits until age 65 or to your Social Security normal retirement age, if later.

Please Check One Box

I REQUEST COVERAGE for the long term/short term disability plan underwritten by The Hartford, as now or hereafter applicable to me, and authorize the appropriate deductions from my wages.

Waiting Period (before benefits begin, if disabled):

- ❑ **30 Days**
- ❑ **60 Days**
- ❑ **120 Days**

Employee Signature: _____Date: _____

Mail the completed form to us at College Benefits Group, LLC PO Box 522, Storrs, Connecticut 06268-0522. You can also email the form to rob@collegebenefitsgroup.com. Your premiums will be deducted automatically from your paycheck and will change as your as your age, salary and/or benefits may change. You also authorize The Hartford or its representatives or successors to obtain employee information from the UConn payroll department in the event of a claim. A certificate of insurance with detailed information is available at: www.collegebenefitsgroup.com

This Section to Be Completed by Employer	
Effective Date of Coverage Change	Employee #
Salary $	UBox #