

Benefits Enrollment Form for UNIVERSITY CORPORATION, CSU NORTHRIDGE
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)

DEPENDENT INFORMATION (ADDITIONAL CHILDREN MAY BE LISTED ON SEPARATE PAPER AND ATTACHED TO/SUBMITTED WITH THIS FORM)
Spouse Name (FIRST MI LAST) Date of Birth Gender Date Married/Partnered
Child Name (FIRST MI LAST) Date of Birth Gender

BASIC TERM LIFE INSURANCE
Coverage for Employee Only Benefit Amount Semi-monthly Premium Amount Elect Coverage Decline Coverage
Employee 1 x annual earnings, up to \$400,000 Paid by Employer [X] [ ]
Additional Information:
• The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 70.

SUPPLEMENTAL TERM LIFE INSURANCE
Coverage for Employee Only Benefit Amount – Select One Option Semi-monthly Premium Amount
Employee [ ] 1 x annual earnings, up to \$500,000 \$
[ ] 2 x annual earnings, up to \$500,000 \$
[ ] 3 x annual earnings, up to \$500,000 \$
[ ] 4 x annual earnings, up to \$500,000 \$
[ ] 5 x annual earnings, up to \$500,000 \$
[ ] Decline Employee Coverage N/A

Spouse	<input type="checkbox"/> \$10,000	\$1.15
	<input type="checkbox"/> Decline Spouse Coverage	N/A
Child(ren) • The premium amount(s) shown apply to all children, regardless of the number of children you have	<input type="checkbox"/> \$5,000	\$0.41 for all children
	<input type="checkbox"/> Decline Child(ren) Coverage	N/A

**Additional Information:**

- If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of \$300,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.
- Your benefit amount is based on your annual earnings; therefore, your benefit and premium amount will change as your earnings change.
- The premium amount(s) for you are based on your age; therefore, the premium amount(s) will change as you grow older.
- The child benefit amount listed applies to any child age 6 months or older. A different amount may apply to any child under the age of 6 months.

**VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE**

Coverage Tier – Select One Option		Employee Benefit Amount – Select One Option	Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)	
			EE Only	Family
<input type="checkbox"/> Employee Only (EE Only)	<input type="checkbox"/> Employee & Family (Family)	<input type="checkbox"/> 1 x annual earnings, up to \$500,000	\$ _____	\$ _____
		<input type="checkbox"/> 2 x annual earnings, up to \$500,000	\$ _____	\$ _____
		<input type="checkbox"/> 3 x annual earnings, up to \$500,000	\$ _____	\$ _____
		<input type="checkbox"/> 10 x annual earnings, up to \$500,000	\$ _____	\$ _____
<input type="checkbox"/> Decline Coverage		N/A	N/A	

**Additional Information:**

- Your benefit amount is based on your annual earnings; therefore, your benefit and premium amount will change as your earnings change.

**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.

**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	

<b>Contingent Beneficiary(ies)</b> (CONTINGENT(S) WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS ALIVE AT THE TIME OF YOUR DEATH)				
<b>1) Name</b> (FIRST MI LAST)	<b>Date of Birth</b>	<b>SSN</b>	<b>Relationship to You</b>	<b>Percent</b> %
<b>Address</b> (STREET, CITY, STATE & ZIP)			<b>Phone Number</b>	
<b>2) Name</b> (FIRST MI LAST)	<b>Date of Birth</b>	<b>SSN</b>	<b>Relationship to You</b>	<b>Percent</b> %
<b>Address</b> (STREET, CITY, STATE & ZIP)			<b>Phone Number</b>	

<b>CONFIRMATION &amp; SIGNATURE</b>	
<p>By signing below:</p> <ul style="list-style-type: none"> <li>• I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.</li> <li>• 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 complete 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) This enrollment form along with the insurance policy, the insurance certificate, any riders or applications describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) 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 6) 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.</li> <li>• 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.</li> <li>• I have read and understand the "Important Notice – Fraud Warning Statements" that applies to my state of residence.</li> </ul>	
<b>Employee Signature</b>	<b>Date of Signature</b>

**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

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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, Virginia 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.

# Premium Worksheet



Rates and/or benefits may be changed on a class basis. Rates are based on the employee's age and increase as you enter each new age category.

<b>SUPPLEMENTAL TERM LIFE INSURANCE</b>													
<b>Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)</b>													
Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
Rate	\$0.0250	\$0.0300	\$0.0400	\$0.0500	\$0.0650	\$0.0950	\$0.1500	\$0.2550	\$0.3600	\$0.6450	\$1.0650	\$1.0650	\$1.0650

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

$$\frac{\text{Benefit Amount}}{\div \$1,000} \times \text{Rate} = \text{Premium Amount}$$

<b>SPOUSE/PARTNER SUPPLEMENTAL TERM LIFE INSURANCE</b>			
<b>Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)</b>			
Benefit Amount	Premium Amount	Benefit Amount	Premium Amount
\$10,000	\$1.15		

<b>CHILD(REN) SUPPLEMENTAL TERM LIFE INSURANCE</b>	
<b>Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)</b>	
Benefit Amount	Cost For All Children
\$5,000	\$0.41

5962a NS 07/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

<b>VOLUNTARY ACCIDENTAL DEATH &amp; DISMEMBERMENT (AD&amp;D) INSURANCE</b>	
<b>Semi-monthly Premium Amount (Cost per Pay Period – 24/Year)</b>	
Coverage Tier	Rate
Employee Only	\$0.0150
Employee & Family	\$0.0200

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

$$\frac{\text{Benefit Amount}}{\div \$1,000} \times \text{Rate} = \text{Premium Amount}$$

5962c NS 07/21 Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.

## The Buck's Got Your Back®

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting company Hartford Fire Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the underwriting company listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. © 2020 The Hartford.

This document 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 document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.

# GROUP LONG-TERM DISABILITY INSURANCE BENEFIT HIGHLIGHTS



More than 1 in 4 adults in the U.S. has some type of disability.<sup>1</sup>

## UNIVERSITY CORPORATION, CSU NORTHRIDGE

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/employee-benefits/employees](https://thehartford.com/employee-benefits/employees)

## COVERAGE INFORMATION

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
66.67%	\$7,500		After 180 days disabled	Disabled before: Age 63 Benefit duration: As long as you are disabled Benefit duration maximum: The greater of your Social Security Normal Retirement Age or 3.5 years

## ASKED & ANSWERED

### WHO IS ELIGIBLE?

You are eligible if you are an active full time manager who works at least 30 hours per week on a regularly scheduled basis.

### AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your health.

This coverage is subject to a pre-existing condition exclusion. Please refer to the Limitations & Exclusions sheet provided with this benefit highlights sheet for more information on limitations and exclusions, such as pre-existing conditions.

### 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?

Your employer will automatically enroll you for this coverage.

### WHEN DOES THIS INSURANCE BEGIN?

This insurance will become effective on the date you become eligible. 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?

Disability is defined in The Hartford's certificate with your employer. Typically, disability means that you cannot perform with reasonable continuity the essential duties necessary to pursue your usual occupation in the usual or customary way. Once you have been disabled for 24 months following the elimination period, you are unable to engage with reasonable continuity in any occupation.

Pre-disability earnings are defined in your policy.

<sup>1</sup>Center for Disease Control and Prevention "Disability Impacts All of Us," September 2020: <https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html>, as viewed on 10/14/2020.

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The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation practices, please review our website <http://thehartford.com/group-benefits-producer-compensation>. Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

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# BASIC and SUPPLEMENTAL GROUP TERM LIFE INSURANCE BENEFIT HIGHLIGHTS



More than half of Americans  
(53%) expressed a  
heightened need for life  
insurance because of  
COVID-19.<sup>1</sup>

## UNIVERSITY CORPORATION, CSU NORTHRIDGE

The group term life insurance available through your employer gives extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life insurance is disbursed to your beneficiaries in a lump sum in the event of your death.



To learn more about Life insurance, visit  
[thehartford.com/employee-benefits/employees](https://thehartford.com/employee-benefits/employees)

## COVERAGE INFORMATION

APPLICANT	BASIC COVERAGE	SUPPLEMENTAL COVERAGE
Employee	Benefit <sup>2</sup> : 1.5x earnings Maximum: \$400,000	Benefit: 1x earnings; 2x earnings; 3x earnings; 4x earnings; or 5x earnings Maximum: the lesser of 5x earnings or \$500,000
Spouse	Not Included	Benefit: \$10,000 Maximum: 50% of your supplemental coverage
Child(ren)	Not Included	Benefit: \$5,000

## ASKED & ANSWERED

### WHO IS ELIGIBLE?

You are eligible if you are an active full time manager who works at least 20 hours per week on a regularly scheduled basis. Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

### CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to "spouse" in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

### AM I GUARANTEED COVERAGE?

Basic insurance is guaranteed issue coverage – it is available without having to provide information about your health.

If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of \$300,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

For your spouse coverage, if you are newly eligible, this coverage is offered without requiring your spouse to provide evidence of insurability. If you were previously eligible and are electing coverage for the first time, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

Supplemental insurance is guaranteed issue coverage – it is available without having to provide information about your child(ren)'s health.

### WHEN CAN I ENROLL?

Your employer will automatically enroll you for basic coverage. If you have not already done so, you must designate a beneficiary.

You may enroll in supplemental coverage during any scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of any eligibility waiting period established by your employer.

### WHEN DOES THIS INSURANCE BEGIN?

Basic insurance will become effective for you on the date you become eligible.

Subject to any eligibility waiting period established by your employer, supplemental 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. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility).

<sup>2</sup>Your basic life benefit will be reduced by 30% at age 65, 55% at age 70, 70% at age 75 and 80% at age 80. Reductions will be applied to the original amount.

**WHEN DOES THIS INSURANCE END?**

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, or the coverage is no longer offered.

**CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?**

Yes, you can take this life coverage with you. Coverage may be continued for you and your dependent(s) under a group portability certificate or an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion and portability are described in the certificate.

<sup>1</sup>Source: LIMRA, Facts About Life 2020: <https://www.limra.com/globalassets/limra/newsroom/fact-tank/fact-sheets/liam-facts-2020-final.pdf>, as viewed on October 14, 2020.

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The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding The Hartford's compensation practices, please review our website <http://thehartford.com/group-benefits-producer-compensation>. Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

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# GROUP VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS



A preventable-injury-related death occurs every 3 minutes in the United States. On average, this means there are 19 deaths and 5,310 medically consulted injuries every hour.<sup>1</sup>

## UNIVERSITY CORPORATION, CSU NORTHRIDGE

Group Voluntary Accidental Death & Dismemberment (AD&D) insurance pays your beneficiary a death benefit if you die due to a covered accident or pays you if you are unexpectedly injured in a covered accident. The benefits are paid in lump sum amounts to you (or your beneficiary), and can be used to pay for health care expenses not covered by your major medical insurance, out of pocket costs, funeral expenses, or however you choose. Accidental death benefits are paid in addition to any life insurance.



To learn more about AD&D insurance, visit [thehartford.com/employee-benefits/employees](https://thehartford.com/employee-benefits/employees)

## COVERAGE INFORMATION

You (the primary insured) may enroll for one of the following AD&D coverage amounts<sup>2</sup>: 1x earnings; 2x earnings; 3x earnings; 4x earnings; 5x earnings; 6x earnings; 7x earnings; 8x earnings; 9x earnings; or 10x earnings. The maximum amount you can elect is the lesser of 10 x earnings or \$500,000.

You may also enroll your dependent(s) for AD&D coverage. Your dependent(s) will be covered at a percentage of your coverage amount.<sup>2</sup>

COVERAGE TIER	SPOUSE PERCENTAGE	CHILD(REN) PERCENTAGE
Spouse	50%	0%
Child(ren)	0%	15%
Spouse & Child(ren)	40%	10%

### AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT

Covered accidents or death can occur up to 365 days after the accident. The total benefit for all losses due to the same accident will not exceed 100% of your coverage amount.

LOSS FROM ACCIDENT	COVERAGE AMOUNT
Life	100%
Both Hands or Both Feet or Sight of Both Eyes	100%
One Hand and One Foot	100%
Speech and Hearing	100%
Either Hand or Foot and Sight of One Eye	100%
Movement of Both Upper and Lower Limbs (Quadriplegia)	100%
Movement of Both Lower Limbs (Paraplegia)	75%
Movement of Both Upper and Lower Limbs of One Side of Body (Hemiplegia)	50%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing	50%
Thumb and Index Finger of Either Hand	25%

## ASKED & ANSWERED

### WHO IS ELIGIBLE?

You are eligible if you are an active full time employee manager who works at least 20 hours per week on a regularly scheduled basis.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

### **CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?**

Yes. Any reference to "spouse" in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

### **AM I GUARANTEED COVERAGE?**

This insurance is guaranteed issue coverage – it is available without having to provide information about your or your family's health.

### **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 31 days of the completion of any eligibility waiting period established by your employer.

### **WHEN DOES THIS INSURANCE BEGIN?**

Subject to any eligibility waiting period established by your employer, 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. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

### **WHEN DOES THIS INSURANCE END?**

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

### **CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?**

Yes, you can take this coverage with you. Coverage may be continued for you and your dependent(s) under an individual conversion certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion are described in the certificate.

<sup>1</sup>National Safety Council, Dec. 2018, <https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/minute-by-minute/data-details/>, as viewed as of 10/14/2020.

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The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding The Hartford's compensation practices, please review our website <http://thehartford.com/group-benefits-producer-compensation>. Accidental Death & Dismemberment Form Series includes GBD-1000, GBD-1300, or state equivalent.

# 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 LIFE INSURANCE

### GENERAL LIMITATIONS AND EXCLUSIONS

- Your basic life benefit will be reduced by 30% at age 65, 55% at age 70, 70% at age 75 and 80% at age 80. Reductions will be applied to the original amount.
- A supplemental or voluntary life benefit will not be paid if death occurs by suicide within two years (or as allowed by state law) of purchasing this coverage.
- 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 dependents 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.
- Coverage may not be elected for a dependent who is in active full-time military service.
- Child(ren) may only be covered as a dependent of one employee.
- Infants may receive a reduced benefit prior to the age of six months.

## GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

### GENERAL LIMITATIONS AND EXCLUSIONS

- 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 dependents 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.

### 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.

5962a NS 05/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

## GROUP LONG TERM DISABILITY INSURANCE

### LIMITATIONS AND EXCLUSIONS

#### 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 3 months before 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 LIMITED BENEFITS.**

This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.

In New York: This Disability policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

5962d NS 05/21 Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

**The Buck's Got Your Back®**

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