HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

The Arc
For people with intellectual and developmental disabilities

THE HARTFORD

Group Term Life Insurance Enrollment Form
With Graded Death Benefit
Members age 60 and younger
Group Policyholder: The Arc of the United States
Policy Number: AGL-1935

SECTION 1			
Member Information			
Member's Name:		**Association Membership Number:**	
☐ **Are you a Member of the Association?**			
Street:	**City:**	**State:**	**Zip Code:**
Member's Social Security Number:	**Member's Date of Birth:**		**Gender:** ☐ **M** ☐ **F**
Email Address:		**Preferred Phone #:**	

SECTION 2
Coverage Information
Life Insurance
Member: ☐ $5,000 ☐ $10,000
By enrolling for this insurance, do you intend to replace, discontinue or change an existing policy of Life Insurance? If not, simply check "No". Member: ☐ Yes ☐ No

Mail your completed enrollment form to: **ARC GROUP INSURANCE, P.O. BOX 14533, Des Moines, IA 50306**
Questions? Call: 1-800-503-9230
Email: customerservice.service@getamba.com

SECTION 3
Confirmation
I acknowledge that I have been given the opportunity to enroll in the Plan Name. I certify that I am age 60 and younger, an Association Member and that the above information is true and complete to the best of my knowledge. If I enroll today and want to upgrade coverage at a later date, I may be required to submit Evidence of Insurability. I understand and agree that insurance will go into effect upon receipt of my first premium payment and this form 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 Association can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

I understand that during the first two years of coverage, the benefit payable for death due to sickness will be the premiums paid plus 1% annual interest. After two years of coverage, the benefit payable for death due to sickness will be the full benefit amount. At any time, the benefit payable for death due to accident will be the full amount.

Member's Signature:	Date:

SECTION 4

Payment Options

Automatic Bank Withdrawal (Electronic Funds Transfer):

Name:	Banking Institution:	Routing Number:
Account Number:	Bank Account Type:	☐ Checking ☐ Savings

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 your dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Member's Signature:	Date:

For Residents of Louisiana:
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.