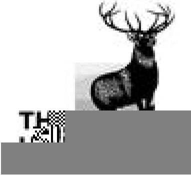

Employer Group Benefits Coverage Information

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Please completely fill out Section 1 and Section 2 on this page and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1: Employer Details *(to be completed by Employer)*	PLEASE PRINT CLEARLY
Employer Name:	Policy Number:
Employer Mailing Address (Street, City, State, Zip Code):	
Division/Location/Subsidiary with Mailing Address *(if applicable):*	
Benefits Contact Name (First, Last):	
Benefits Contact Email Address:	Benefits Contact Phone: ( ) -

Section 2: Employee Details *(to be completed by Employer)*	PLEASE PRINT CLEARLY
Employee Name (First, MI, Last):	Date of Hire (mm/dd/yyyy):

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Form PA-9597

Medical Information

Each Applicant must answer each of the following questions to the best of their knowledge and belief. A Legal Guardian is required to answer each of the questions for minor children. If you have

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Notice

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Fraud

For your protection, California law requires the following to appear on this form: The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with the actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Certification

I hereby represent that I have reviewed the above questions and that all statements and answers contained herein are full, complete, and true to the best of my knowledge and belief. For residents of Virginia only: I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

This application will be made a part of the Policy.

______________________	/ /	______________________	/ /
Employee Signature	Date Signed	Spouse Signature	Date Signed

/ /

Child Signature
(Parent/Legal Guardian of the Child is required to sign when submitting dependent Evidence of Insurability on a minor child.)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.