

HARTFORD

PHYSICIAN GROUP ENROLLMENT/CHANGE FORM

EMPLOYER INFORMATION	
EMPLOYER'S FULL LEGAL NAME Delaware Cardiovascular Associates	GROUP POLICY

ENROLLMENT INFORMATION	
PLEASE CHECK ONE OF THE FOLLOWING:	
<input type="checkbox"/> INITIAL ENROLLMENT	
<input type="checkbox"/> CHANGE TO EXISTING ENROLLMENT	
<input type="checkbox"/> NAME / ADDRESS CHANGE (FORMER NAME) _____	<input type="checkbox"/> (BENEFICIARY CHANGE)
(LIFE/AD&D OR _____ SUPP LIFE)	
<input type="checkbox"/> COVERAGE CHANGE ADD _____	DELETE: _____ EFFECTIVE DATE _____
<input type="checkbox"/> FAMILY STATUS CHANGE (TYPE) _____	EFFECTIVE DATE _____

EMPLOYEE INFORMATION				
EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	GENDER	MARITAL STATUS	SOCIAL SECURITY NUMBER
EMPLOYEE'S HOME ADDRESS	CITY	STATE	ZIP	
SPECIALTY/OCCUPATION	# HOURS WORKED PER WEEK	DATE OF HIRE		

BENEFICIARY INFORMATION				
PRIMARY LIFE BENEFICIARY NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	% OF BENEFIT
PRIMARY LIFE BENEFICIARY NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	% OF BENEFIT
CONTINGENT LIFE BENEFICIARY NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	% OF BENEFIT

Note: If additional space is needed, use back of form. Your beneficiary designation can be changed at any time. If you are married and/or divorced and reside in a community property state, you should consult with your legal counsel prior to changing your beneficiary. The designation takes effect as of the date the completed form is received and accepted by The Hartford.

APPLICABLE BENEFIT ELECTIONS	
Please make your benefit elections by checking the appropriate box. Contact your employer for plan details.	
SHORT TERM DISABILITY	LIFE AND AD&D*
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

SPOUSE INFORMATION			
SPOUSE'S NAME	SPOUSE'S GENDER	SPOUSE'S SOCIAL SECURITY NUMBER	SPOUSE'S DATE OF BIRTH

APPLICATION FOR COVERAGE	
<p><i>I apply for the group insurance coverage checked above provided under my employer plan. I authorize deductions from my wages to cover my contribution, if required. If I have declined any contributory coverages for which I am eligible above, I understand that to later enroll for these coverages satisfactory medical evidence of insurability will be required and the insurance carrier will have the right to refuse my request. Any person who knowingly, and with the intent to defraud or deceive any insurance company, submits an insurance application containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.</i></p>	
EMPLOYEE SIGNATURE	DATE

DECLINATION OF COVERAGE (IF APPLICABLE)	
<p><i>I refuse the contributory coverages offered by my employer. The group insurance available to me through my employer has been explained to me. After careful consideration, I have decided that I do not want to enroll for the plans offered above. I understand that if I choose not to enroll for all of the coverages for which I am eligible, within 31 days after I become eligible, satisfactory medical evidence of insurability will be required and the insurance carrier will have the right to refuse my request.</i></p>	
EMPLOYEE SIGNATURE	DATE