Hartford Life and Accident Insurance Company	HSTA Voluntary Employees Beneficiary Association Trust Long Term Income Protection Plan Enrollment Application

□ New Enrollment □ Change (Name/Address/Salary/Benefit/Elimination) □ Cancel

Social Security #	Name (last, first, middle initial)		
HSTA VEBA Trust #	Street Address		
☐ Male ☐ Female	City	State	Zip Code
Date of Birth / /	Home Telephone	School/Work Telephone	
Name of School	Gross Monthly Salary	Occupation	

Choose Your Benefit Level: ◯ 50% Level ◯ 60% Level ◉ 66 2/3% Level

Choose Your Elimination (Benefit Waiting) Period: ☐ 6 months ☐ 9 Months

◉ **I REQUEST COVERAGE** under the Long Term Disability Plan through the HSTA VEBA Trust group contract, as now or hereafter applicable to me and agree to the following:

- I authorize monthly deductions from my employee salary/wages to cover my cost of coverage when applicable.
- I am responsible for notifying the HSTA VEBA Trust of any change in Gross Monthly Salary and for completing a new enrollment application.
- I understand and agree that insurance will go into effect 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 HSTA VEBA Trust can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment application and the insurance policy, I agree to be bound by the insurance policy.
- I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to HSTA VEBA Trust. I acknowledge and agree that if group participation requirements are required by Hartford Life and Accident Insurance Company or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force.
- If I have disability income coverage with Hartford Life and Accident Insurance Company, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

◯ **I DECLINE COVERAGE**. I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by HSTA VEBA Trust. I understand and agree that if I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to Hartford Life and Accident Insurance Company and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by Hartford Life and Accident Insurance Company.

Employee Signature: _____Date:_____

HSTA-VEBA Trust use	Effective/Change Date:	Termination Date:

This disability plan is underwritten by: Hartford Life and Accident Insurance Company
200 Hopmeadow Street
Simbury, CT 06089

REV 2018