



Underwriting Company

- Hartford Life and Accident Insurance Company
- Hartford Life Insurance Company

## Your Conversion Privilege

**This information describes the plan of total disability insurance available to insured persons who desire to convert their group long term disability benefits.**

An enrollment form and complete instructions on how to enroll in the plan of total disability insurance are included at the end of this form.

### Are you eligible for conversion insurance?

You are eligible to convert to total disability insurance if you:

1. Have been insured under your employer's Hartford group long term disability policy for at least one year;
2. Apply for conversion within 31 days after you terminate employment; and
3. Are not retiring.

### You are not eligible for conversion insurance if...

1. Your employer's group long term disability policy terminates;
2. You were required to pay premiums under your employer's policy but failed to do so;
3. You no longer belong to a class of employees eligible for coverage under your employer's policy;
4. You are disabled under your employer's policy; or
5. You become insured, within 31 days after termination of your group long term disability coverage, under another plan of disability insurance provided by an employer.

### When does your conversion insurance become effective?

Your conversion insurance becomes effective the day you are no longer covered by your employer's Hartford disability income policy.

### What is total disability?

A monthly benefit will be paid for each month of total disability. Total disability means that, because of injury or sickness, you are:

1. Continuously unable to engage in any occupation for which you are or become qualified by education, training or experience; and
2. Under the regular care of a licensed physician other than yourself.

Please note that this definition of total disability is different from the definition used for your employer's plan of group long term disability insurance.

### What will your monthly benefit be... and how long will you receive it?

The monthly benefit you will receive if you are totally disabled is equal to 50% of your monthly salary on your last day of employment, up to a maximum of \$1,000 per month.

The elimination period is 180 days. This means that you must be totally disabled for 180 consecutive days before you can begin receiving your monthly benefit.

You are eligible to receive monthly benefits for a maximum of 2 years if you are age 63 or younger when total disability starts; one year if you are age 64 or older when total disability starts.

The monthly benefit will be reduced by 1 and 2 below:

1. Disability or retirement benefits paid or payable under:
  - a. The Social Security Act, including amounts for which your dependents may qualify because of your disability or retirement;
  - b. A Workers' Compensation or occupational disease act or law; and
  - c. A state disability benefit law.
2. Disability or retirement benefits paid under an employer's group insurance, sick leave or retirement plan.

The monthly benefit will never be reduced below \$50.

After these reductions, the monthly benefit will not be further reduced for cost of living increases under the benefits described above.

### What the conversion policy does not cover

No benefits will be paid for total disability resulting from:

1. Declared or undeclared war or an act of either; or
2. Service in the armed forces of any country. However, orders to active military service for 2 months or less will not constitute service in the armed forces.

## When will your coverage terminate?

Your conversion insurance will terminate on the earliest of the following dates:

1. On the premium due date following 31 days written notice of non-renewal from The Hartford; or
2. At the end of the 31 day grace period, if you fail to pay a premium.

## What your premium will be

Premium Rate Table\*  
(per \$100 of Monthly Benefit)

Age at Premium Due Date**	Annual Rate	Semi-Annual Rate
Under 30	\$10.50	\$ 5.75
30-34	15.75	8.38
35-39	20.25	10.63
40-44	24.00	12.50
45-49	31.50	16.25
50-54	51.00	26.00
55-59	65.50	33.25
60 and over	82.75	41.88

\* Rate table is subject to change.

\*\*Your premiums will increase based on your age on the premium due date.

## How to calculate your premium

This example calculates the *annual* premium for an individual with the following characteristics:

- Current age: 29
- Annual rate for current age: \$10.50
- Monthly salary on the date employment terminated: \$1,965

Follow these steps to fill in numbers 1 through 3 on the Worksheet.

1. Multiply the monthly salary by .50. ( $\$1,965 \times .50 = \$982.50$ ) The monthly benefit is equal to the lesser of:
  - a. 50% of your monthly salary at termination of employment, or
  - b. \$1,000.In this example, the monthly benefit is \$982.50. This is rounded up to the next dollar: **\$983**.
2. Divide #1 by 100. ( $\$983/100 = \$9.83$ )
3. Multiply #2 by the appropriate rate. ( $9.83 \times \$10.50 = \$103.21$ )

This is the annual premium.

## Premium Worksheet

- Your age: \_\_\_\_\_
- Rate for your age: \_\_\_\_\_  
(See the premium rate table and select either annual or semi-annual payment.)
- Monthly salary on the date employment terminated:  
\_\_\_\_\_

Calculate your premium by following the step-by-step example above.

1. Multiple your monthly salary by .50 and round up to the next dollar = \$ \_\_\_\_\_  
This amount, or \$1,000, whichever is less, equals your monthly benefit.
2. Divide your monthly benefit by 100 = \_\_\_\_\_
3. Multiply #2 by the rate for your age = \_\_\_\_\_  
This equals your annual or semi-annual premium for the mode of payment you selected. Your premiums will increase as stated in the Premium Rate Table.

## How and when to apply for conversion

Complete the enrollment form below and make sure your employer completes the "Employer/ Policyholder" section. Send this form with a check or money order, payable to The Hartford, to the address shown below.

## Instructions for Completing the Enrollment Form

- 1-5 Provide the information requested.
6. Enter your monthly benefit. (See Number 1 of the Premium Worksheet.)
7. Indicate the mode of premium payment you prefer.
8. Enter your premium. (See Number 3 of the Premium Worksheet.) Your check for the premium shown must accompany the enrollment form.

Be sure to date and sign the enrollment form.

This is not a contract of Insurance. Complete details of coverage will be explained in your Certificate of Total Disability Insurance.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company and Hartford Life Insurance Company.

Disability coverage is underwritten under policy form number P1-54956-A.



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**CONVERSION ENROLLMENT FORM FOR  
TOTAL DISABILITY INSURANCE**

**(Please Print) For Completion by Employer/Policyholder**

Policyholder's Name \_\_\_\_\_ Employee's Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Monthly salary at the time of termination \$ \_\_\_\_\_

Reason for termination of coverage under above policy \_\_\_\_\_

Date employee's coverage under above policy terminates \_\_\_\_\_ Occupation \_\_\_\_\_

Duties \_\_\_\_\_

**Completed by** \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

\_\_\_\_\_ (Name-Please Print) \_\_\_\_\_ (Title)

**Employer Telephone # (\_\_\_\_\_) \_\_\_\_\_ Employee Telephone # (\_\_\_\_\_) \_\_\_\_\_**

**(Please Print) For Completion by Employee**

I apply to The Hartford for conversion insurance providing total disability benefits. I have read and clearly understand the conversion procedures set before me and wish to enroll at this time.

1. Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI)

2. Sex M F 3. Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 4. Social Security # \_\_\_\_\_

5. Residence Address \_\_\_\_\_ (Street) \_\_\_\_\_ (Apt) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

6. Monthly Benefit \$ \_\_\_\_\_ 7. Mode of premium Annual Semi-annual

8. My check made out to The Hartford in the amount of \$ \_\_\_\_\_ is enclosed.

The statements above are true to the best of my knowledge and belief.

\_\_\_\_\_  
Signature Date Signed

**MAIL THIS FORM TO: The Hartford  
ATTN: Conversion and Portability Administration  
P.O. Box 248108  
Cleveland, OH 44124-8108  
1-877-320-0484**