ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PLAN
Enrollment Form

THE HARTFORD

Policy Number: ADD-8467
Please print. Use dark ink. Do not erase. Initial changes. Send in payment with this form.

Policyholder: Insurance Fund of the Commissioned Officers Association
Underwritten by: Hartford Life Insurance Company, Hartford, CT 06155

Member:

Member Name: (FIRST, MIDDLE, LAST)

Address:

City: State: Zip: Birth Date: / /

Gender: ○ Male ○ Female Email: (optional)

I hereby apply for the following coverage: ○ Member Only ○ Member & Spouse ○ $100,000 ○ $200,000 ○ $250,0000

Age 70 – Benefits reduce to 50%; Age 75 – Benefits reduce to 25%. Spouse is eligible for 50% of Member's coverage.

Your beneficiary for this coverage will be your legal spouse, if living. If you have no spouse, your beneficiary will be your children, your parents, your brothers and sisters, or your estate, in that order. The member is the beneficiary for spouse and children's coverage.

Spouse: *(if enrolling)*

Spouse Name: (FIRST, MIDDLE, LAST)

Spouse's Date of Birth: / / Family coverage is a percentage of Member's coverage.

Authorization:

I hereby enroll with Hartford Life Insurance Company of Hartford, CT, for coverage under the Accidental Death and Dismemberment Plan, ADD-8467. I have read and understand the conditions and exclusions of the program. I understand that my coverage will become effective upon the first day of the month following the administrator's receipt of this enrollment form and my first premium payment.

X _____ Member's Signature (Required)

/ / Today's Date *(mo/day/year) (Required)*

X _____ Spouse's Signature (Required if enrolling)

/ / Today's Date *(mo/day/year) (Required if enrolling)*

Your first payment must accompany this enrollment form. Make your check payable to COA Group Insurance Services.

Please mail your signed Enrollment Form and Payment to:
COA Group Insurance Program, P.O. Box 21057, Santa Barbara, CA 93121-9956