

**CHANGE IN BENEFICIARY OR SUPPLEMENTAL LIFE CHANGE FORM  
EMPLOYEE BASIC AND GROUP SUPPLEMENTAL TERM LIFE INSURANCE**

**HARTFORD LIFE AND ACCIDENT  
INSURANCE COMPANY**

**1. Fill in the following blocks for all coverages:**

Employee Last Name		First	M.I.	Employer
				<b>Roman Catholic Archdiocese of Atlanta</b>
Employee Address		City		State
				Zip
Office Name & Number			Employee Classification	Employee No.
S.S. #	Date of Birth	Sex		This section for Employer to complete: Wages \$ <u>N/A</u> /year Date of Hire _____/_____/_____
- -	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female		

**2. Enter the requested change in the amount of supplemental life insurance coverage, which may not exceed the maximum amount of insurance for which you are eligible under the policy described in this brochure:**

**EMPLOYEE BASIC LIFE & AD&D \$50,000** – Provided by the Roman Catholic Archdiocese of Atlanta.

**NO CHANGE TO EMPLOYEE SUPPLEMENTAL LIFE** – Initial enrollment or most recent supplemental life change form on file is in effect. Note: If no change is indicated below, current election remains in force even if “No Change” is unmarked.

**CHANGE EMPLOYEE SUPPLEMENTAL LIFE – Effective date determined by approval from Hartford Life.**  
From \$ \_\_\_\_\_ Change to: \$ \_\_\_\_\_ (Increments of \$10,000 to a maximum \$250,000.) Note: Evidence of good health will be required for all coverage elections or increases after your initial enrollment period.

**NO CHANGE TO SPOUSE SUPPLEMENTAL LIFE** – Initial enrollment or most recent supplemental life change form on file is in effect. Note: If no change is indicated below, current election remains in force even if “No Change” is unmarked.

**CHANGE SPOUSE SUPPLEMENTAL LIFE – Effective date determined by approval from Hartford Life.**  
From \$ \_\_\_\_\_ Change to: \$ \_\_\_\_\_ (Increments of \$10,000 to a maximum \$100,000.) Note: Evidence of good health is required for all coverage elections or increases after your initial enrollment period.

**NO CHANGE TO CHILD(REN) LIFE** – Initial enrollment or most recent supplemental life change form on file is in effect.

**CHANGE CHILD(REN) LIFE – Effective upon date received by employer and subject to immediate payroll deduction.**  
**Note: Life amount elected is a per child amount, effective for all dependent children.**  
From \$ \_\_\_\_\_ Change to: \$ \_\_\_\_\_ (Increments of \$2,000 to a maximum of \$10,000 per child.)

**3. Complete if applying for spouse and/or children’s coverage:**

Spouse Last Name			First	M.I.	Names of Children	Dates of Birth
Spouse Date of Birth		S.S. #				
/ /		- -				

**4.  NO CHANGE - COMPLETE SECTION BELOW ONLY IF CHANGING BENEFICIARY DESIGNATION ON FILE:**

I hereby rescind my previous beneficiary designations and make the following beneficiary designations which replace and supercede all previous designations made before the date signed below:

Primary Beneficiary Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Secondary Beneficiary Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

*A beneficiary may be changed upon written request. The beneficiary for life insurance on the lives of your spouse or children will automatically be you, if surviving, otherwise your estate, subject to policy provisions.*

**5. Are you actively working on a regular basis?  Yes  No**

This means you are performing in the usual way, all of the regular duties of your job on a regularly scheduled basis, at least 30 hours per week. If “No”, explain:  
\_\_\_\_\_

**6. Please read the certification statement, then sign, date and return this form to your Benefits Office.**

I hereby apply for the changes in my Group Supplemental Term Life Insurance plan, and if applicable make the changes in beneficiaries, as shown above and authorize my employer to make the appropriate payroll deductions for the additional coverage(s) applied for upon their approval. I understand that late enrollments or increases in my Employee and/or Spouse Supplemental Life coverages do not become effective until approved by The Hartford. I represent that the statements above are true and complete to the best of my knowledge and belief and are binding on any person claiming an interest in the coverage issued.

\_\_\_\_\_

Employee’s Signature \_\_\_\_\_ Date