Notice of Continuation of Coverage

As a terminated employee – or as an active employee or retiree – losing coverage or a portion of coverage under your employer's Group plan, you may be eligible to continue all or a portion of that coverage without submitting evidence of good health. Potential options are explained below. The specific options available to you are based on the provisions as defined in the Group plan. Included with this notice is a form you can submit to obtain additional information. You will receive details on the specific coverage options available to you, rates, and the necessary forms to enroll.

Standalone Accidental Death and Dismemberment (SAAD&D) Conversion

Under this conversion option, you may convert your Employer Group Standalone Accidental Death and Dismemberment coverage to a group conversion policy. Subject to certain limitations and exclusions, this policy covers you against death and dismemberment caused by an accident, 24 hours a day anywhere in the world, whether you are traveling or are at work or play. The Principal Sum you elect to convert cannot exceed the lesser of the Principal Sum you carried under your group plan or the state maximum shown below. Coverage automatically decreases to $25,000 upon reaching age 70 and to $12,500 upon reaching age 75. The conversion option may be available to your dependents if you carried dependent coverage under your employer's group plan. **Premiums for a Standalone Accidental Death and Dismemberment Conversion policy are higher than your Employer Group plan rates.**

Non-NY Residents may choose any amount between $25,000 and $250,000 in $1,000 increments. Rates increase upon reaching age 75 but you are not subject to an age limit.

NY Residents ONLY may choose any amount between $10,000 and $100,000 in $10,000 increments. Rates will not increase and you are not subject to an age limit.

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Attached is a form that contains additional information about continuing coverage. You can use this to request a quote and the necessary forms to enroll.

Please note that there is a designated timeframe during which you can exercise your coverage continuation options. To continue coverage, **you must mail or fax this form to request information within 15 days from the date of this notice or 31 days from your group coverage termination date, whichever is later. Under no circumstances, however, will continuation of coverage be available beyond 91 days from your group coverage termination date. Any issues regarding late notification by your employer must be addressed with the employer.**

If you have questions about this information, your eligibility, or the status of any request you have submitted, please call a representative at **1-877-320-0484.**

The Hartford, Portability and Conversion Unit
P.O. Box 248108
Cleveland, OH 44124-8108

Fax 1-440-646-9339

Frequently Asked Questions

Q: If I request a quote, how does Hartford determine the amount of coverage to quote?
A: Hartford will contact your employer to obtain the amount of coverage you had in effect under the group plan. The quote is based on this amount as well as applicable plan provisions.

Q: If I receive a quote for coverage, does this mean I qualify for the coverage amount quoted?
A: The amount quoted is not a guarantee that a policy will be issued in that amount. Upon receipt of your application for coverage, Hartford will perform an eligibility review to determine that the amount of coverage you have requested can be granted based on the coverage you had in effect under the group plan as well as plan provisions.

Q: What is my policy effective date?
A: The effective date of an SAAD&D policy is the day following the group coverage termination date.

Q: If my application for coverage is not approved by the effective date, am I still covered?
A: Yes, if your application is approved the effective date of your policy will be retroactive to the date indicated above.

Q: I understand that there is no medical underwriting or physical exam required but can I still be denied for coverage?
A: Your request for coverage can be denied if you do not meet the timeliness requirement. You must mail or fax this form to request information within 15 days from the date of this notice or 31 days from your group coverage termination date, whichever is later. Under no circumstances will continuation of coverage be available beyond 91 days from your group coverage termination date. Coverage can also be denied if it exceeds the amount you had in effect under your employer's Group plan or if it does not align with you employer's plan provisions. In addition, any request for coverage that is not available under your employer's Group plan will also be denied.

Q: If I start to work for a new employer and obtain coverage under that employer's Group plan, will that Group coverage impact any conversion or portability policy that I may have purchased?
A: If you obtain coverage under a new employer's Group plan, your portability or conversion policy will remain in effect provided you continue to pay the required premiums. However, benefits under conversion policies may be affected by the amount of your other coverage.

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Employer:_____ Policy #:_____

The following information is to be completed by Employer or Employer Representative

Employee Name:_____ Employee ID#:_____ Date:_____

Last Day Worked (or date employee is no longer in an eligible class):_____

Date of Group Coverage Termination:_____ Termination Reason:_____

Signature_____ Print Name_____

Email Address_____ Telephone_____

The rates for Standalone AD&D Conversion will be higher than your employer Group plan rates. Standalone AD&D Conversion rates are quoted annually and billed annually or semi-annually.

Employee: To request specific rates and enrollment information, please complete the information below and mail or fax this entire page to:

The Hartford, Portability and Conversion Unit, P.O. Box 248108, Cleveland, OH 44124-8108
Fax 440-646-9339, Phone 877-320-0484

Yes, I am interested in receiving the information checked below.

☐ SAAD&D Conversion

Please print the following information:

Name:_____ Date of Birth:_____

Social Security # **(indicate last 4 digits only):**_____

Address:_____

City:_____ State: _____ Zip Code:_____

Telephone Number:_____ Email:_____

I am interested in receiving information for the following persons:

☐ Myself ☐ My Spouse ☐ My child(ren)

Please print the name(s), relationship, and date(s) of birth for each dependent who may be eligible for coverage. Include an additional sheet if necessary.

Name:_____ Relationship:_____ Date of Birth:_____

Name:_____ Relationship:_____ Date of Birth:_____

Name:_____ Relationship:_____ Date of Birth:_____

Name:_____ Relationship:_____ Date of Birth:_____

I understand that I have only 31 days from the date of my group coverage termination <u>OR</u> 15 days from the date of this notice, whichever is later, to complete and submit this form to The Hartford. In no event, however, will my eligibility to continue coverage exceed 91 days from my group coverage termination date.

_____ _____

Signature (required) **Date**