The Hartford – Client Information Sheet

Plan Coverage – Check all that apply			
Plan	Name of Prior Carrier	Plan	Name of Prior Carrier
☐ Basic Life/AD&D		☐ Voluntary Dependent Life	
☐ Basic Dependent Life		☐ Voluntary Dependent AD&D	
☐ Basic Dependent AD&D		☐ STD – Fully Insured	
☐ Voluntary Life		☐ STD – Self-Insured	
☐ Voluntary AD&D		☐ LTD	

Policyholder Information			
Legal Name:			
Legal Address (no P.O. Box):			
Legal Entity (please select one from the following list):			
☐ Corporation	☐ Municipality	☐ Limited Partnership	☐ Union Group
☐ Partnership	☐ School District	☐ Non-profit	☐ S - Corporation
☐ Proprietorship	☐ Sole Proprietor	☐ Individual	☐ Other
☐ LLC	☐ Sovereign Nation	☐ Trust	

Federal Tax ID:	**Plan Administrator name:**
Effective Date:	Mailing Address: _____
Anniversary Date:	
ERISA Plan Number:	Email Address:
ERISA Plan Year: ☐ Calendar Year (Jan. 1)	Phone Number:
☐ Policy Year (matches Anniversary Date) ☐ Other	Fax Number:

Billing Information	
☐ **List Bill –** provides a list each month documenting covered employees and dependents, benefit levels, premium amounts, etc. Simply send a check for amount due on the bill – The Hartford calculates the premium.	
☐ **Self Administered Bill –** great option if you have a payroll or HR system that maintains and reports employee benefit information in a manner that allows you to capture total benefit volumes for all employees – You calculate the premium.	
Whichever billing option you choose, your monthly bill notice will arrive via email. Provides immediate access to billing information on-line. Allows you to view and print actual invoices, pay online (if desired) – saves time and ensures accuracy.	
When do you want age changes and salary changes to be reflected? ☐ As they occur ☐ January 1st of each year ☐ On each plan anniversary	
Do you require more than one bill sent to a centralized location? No ☐ Yes ☐ If yes, please provide billing contact information for other locations:	
Does the premium and/or claims need to be tracked by location or by specific group of employees? No ☐ Yes ☐ If Yes, please specify on sold census.	
Is the Billing Contact the same as the Plan Administrator noted above? Yes ☐ No ☐	
If No, please provide **Billing Contact name:**	
Address: _____ _____ _____	Email Address:
	Phone Number:
	Fax Number:

CIS v1.0

Employee Location Information

Are there any employees residing in states other than the situs state of the Employer? No ☐ Yes ☐

If Yes, please indicate states:

If you have employees in the following states, please indicate the # in each: CA: _____ MN: _____ UT: _____ WI: _____

Do you have any employees working in ☐ NY ☐ NJ ☐ RI ☐ CA ☐ HI ☐ PR

If yes, are these employees currently covered through the state's mandated disability insurance plan?

No ☐ Yes ☐ If Yes, please indicate which states: _____

Do you have Expatriates, Foreign Nationals or Third Country National employees? (Employees working in a country other than the U.S.). ☐ No ☐ Yes - please include employees' Name, Date of Birth, Country of Citizenship, and Country of Work Location on your census. Coverage is subject to underwriting approval.

Are there any subsidiary companies that are being covered? No☐ Yes☐ If yes, please provide subsidiary's name & address:

Voluntary Enrollment Options

(Complete only if a voluntary line of coverage sold)

Which of the following does your plan administration allow for?

☐ Late enrollees are allowed to join the plan at any time **with evidence of insurability.**

☐ Late enrollees are allowed to join the plan ONLY during the specified enrollment period **with evidence of insurability**.

Annual Enrollment Dates: From to or ☐ To be determined each year by employer

Employee Eligibility Information

Please indicate the waiting period for each class:

	Class		Class
Date of hire		1st of the month after _____ days of employment*	
1st of month following date of hire		1st of the month after _____ month(s) of employment*	
After days of employment			
After month(s) of employment		Other:	

*If the end of the waiting period lands on the first of a month, does the employee's coverage begin that day or on the first of the next month?

Do you have employees hired before this policy effective date who still need to fulfill the waiting period? No ☐ Yes ☐

If the answer is "yes", please ensure the census you submit includes dates of hire.

Please indicate the **minimum number of hours/week** to be eligible for benefits: ☐ 30 hours ☐ 40 hours

If other, please specify the number of hours

Do the class descriptions outlined in your Hartford proposal read exactly as you would like them to read?

No ☐ Yes ☐ If you answer No, then your Hartford Service Consultant will follow-up with you to discuss this.

Earnings Definition

	Applies to Class #		Applies to Class #
☐ Base Salary Only (standard)		☐ Salary plus Commissions*	
☐ Salary plus Bonuses*		☐ K-1 earnings	
☐ Salary plus Commissions & Bonuses*		☐ Prior Year's W-2 (automatically includes commissions, bonuses & overtime)	

*If included, commissions and/or bonuses are averaged over previous: ☐ 12 months ☐ 24 months ☐ 36 months OR ☐ 1 calendar year ☐ 2 calendar years ☐ 3 calendar years If included, please ensure census includes this information.

Do you have any employees that earn income on a basis other than hourly or salaried? If so, please explain.

Do you include overtime in earnings for benefit purposes? No ☐ Yes ☐

Employer & Employee Contributions					
Coverage	**Employer Contribution %**	**Employee Contribution %**	**Coverage**	**Employer Contribution %**	**Employee Contribution %**
Basic Life/AD&D			Dep. Vol. Life		
Basic Dependent Life			Dep. Vol. AD&D		
EE Voluntary Life			STD		
EE Voluntary AD&D			LTD		

Additional Information

Voluntary Dependent Life premium is based on: employee's age ☐ (standard) spouse's age ☐

If STD coverage was purchased, do your employees work a 5 day work week? ☐ Yes ☐ No – please explain your company's work schedules:

Are the Employer paid (non-contributory) disability premiums ☐ pre-tax (standard) ☐ post-tax ☐ optional basis?

Third Party Sickpay Tax Reports will be provided on a quarterly basis. Should your tax report be sent to someone other than the Plan Administrator? If yes, name & email address: _____

Do you use a payroll vendor? ☐ No ☐ Yes

W2 services are available at no charge. FICA match service is included on LTD, free of charge. FICA match service may be available on STD for an additional charge. **W2 & FICA services need to be elected or declined on the W2/FICA Services Agreement.**

Hartford's standard Coverage Continuation provisions are outlined below. If you administer benefits differently, please let us know.

FMLA -- For employers with 50+ employees, our standard is to allow coverage to be continued for up to 12 weeks.

Military Leave -- For employers with 50+ employees, our standard is to allow coverage to be continued for up 12 weeks. For employers with less than 50 employees, we allow coverage to be continued for up to 8 weeks.

Non-FMLA (Personal Leave) – Life insurance coverage can be continued for 1 month. Disability coverage is not continued.

Temporary layoff – Life insurance coverage can be continued for 1 month. Disability coverage is not continued.

Coverage does not continue during a labor dispute, work stoppage, sabbatical or severance period.

Producer Information

Commissions Schedule: _____

Commissions Payable to: _____
Primary Broker: _____
Address: _____ City/State/Zip: _____
Phone: _____ Fax: _____ Email: _____

Is there a commissions split? ☐ Yes ☐ No

Secondary Broker: _____ Split % _____
Agency Name: _____
Address: _____ City/State/Zip: _____
Phone: _____ Fax: _____ Email: _____

This form was completed by:

Printed Name: ___________________________________ Date: _____

Signature: ________________________________ Title: _____