

**American Conference of Cantors
LTD Enrollment Form**

Information About You

Name: _____ Social Security Number: _____

Date of Birth: _____ Date of Hire: _____ Salary: _____

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter or check** your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your association’s contract.*
- **Step 2:** Please **sign, date and return** this form to the ACC Pension and Insurance Plan Administrator, 35 Bay View Ave, Quincy, MA 02169

The following costs should be calculated based on your age and salary as of the effective date.

Voluntary Long Term Disability (LTD) Insurance

You have the opportunity to enroll in the American Conference of Cantors’ Voluntary Long Term Disability insurance plan. LTD insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period, of 90 days. This plan provides you with income protection to replace up to 60% of your regular pay, to a maximum monthly benefit of \$10,000.

Use the rate chart and calculation line below to determine your annual cost for this coverage.*

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Hartford Rate	\$0.1800	\$0.1500	\$0.1800	\$0.3700	\$0.5800	\$0.8100	\$1.0900	\$1.2200	\$1.1400	\$1.1000	\$1.1000	\$1.1000
ACC Admin Fee	\$0.10	\$0.10	\$0.10	\$0.10	\$0.10	\$0.10	\$0.10	\$0.10	\$0.10	\$0.10	\$0.10	\$0.10
Total Cost of Coverage^	\$0.28	\$0.25	\$0.28	\$0.47	\$0.68	\$0.91	\$1.19	\$1.32	\$1.24	\$1.20	\$1.20	\$1.20

I elect to enroll in the Voluntary LTD plan at the annual cost below.*

$$\frac{\text{Annual Salary}}{\text{Maximum} = \$200,000} / 100 = \frac{\text{Rate Above}}{\text{Rate Above}} \times \frac{\text{Your Annual Cost}}{\text{Your Annual Cost}} = \text{Your Annual Cost}$$

I elect to **decline** the Voluntary LTD plan.

*Your cost may change if your age or salary changes within the benefits plan year.

^ The cost of coverage includes the actual disability premium plus a small allowance of (0.10 per \$100) for administrative costs to the plan.

The Hartford is The Hartford Financial Services Group, Inc and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

Associate Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage described in the Benefit Highlight Sheets and offered through American Conference of Cantors.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your association) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my association. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____