

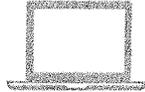
GROUP LONG-TERM DISABILITY INSURANCE BENEFIT HIGHLIGHTS



Town of Rocky Hill - Town Employees

A disability can happen to anyone. Long-term disability insurance helps protect your paycheck if you're unable to work for a long period of time after a serious condition, injury or sickness.

More than 1 in 4 adults in the U.S. has some type of disability.¹



To learn more about Long-Term Disability insurance, visit thehartford.com/employee-benefits/employees

COVERAGE INFORMATION

BENEFIT PERCENTAGE (PERCENT OF YOUR EARNINGS)	MAXIMUM	MINIMUM (BASED ON MONTHLY INCOME LOSS BEFORE THE DEDUCTION OF OTHER INCOME BENEFITS)	BENEFIT STARTS (ELIMINATION PERIOD)	BENEFIT DURATION
67%	\$7,000	The greater of \$100 or 10% of the benefit	After 180 disabled	Disabled before: Age 63 Benefit duration: As long as you are disabled Benefit duration maximum: The greater of your Social Security Normal Retirement Age or 4 years

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee who are subject to Collective Bargaining Agreement Excluding ABPO Local 316 Police who works at least 30 hours per week on a regularly scheduled basis.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your health.

This coverage is subject to a pre-existing condition exclusion. Please refer to the Limitations & Exclusions sheet provided with this benefit highlights sheet for more information on limitations and exclusions, such as pre-existing conditions.

WHEN CAN I ENROLL?

Your employer will automatically enroll you for this coverage.

WHEN DOES THIS INSURANCE BEGIN?

This insurance will become effective on the date you become eligible. You must be actively at work with your employer on the day your coverage takes effect.

WHEN DOES THIS INSURANCE END?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you leave your employer, or the coverage is no longer offered.

WHAT DOES IT MEAN TO BE DISABLED?

Disability is defined in The Hartford's certificate with your employer. Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are less than 80% of your pre-disability earnings. Once you have been disabled for 2 years following the elimination period, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are less than or equal to 60% of your pre-disability earnings.

Pre-disability earnings is your regular monthly rate of pay, not counting commissions, bonuses, overtime pay or any other fringe benefit or extra compensation.

*Center for Disease Control and Prevention "Disability Impacts All of Us." September 2020. <https://www.cdc.gov/ncehd/ndisabilityandhealth/miographic-disability-impacts-all.html>, as viewed on 10/14/2020.

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The Hartford[®] is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting company Hartford Life and Accident Insurance Company, Home Office in Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the underwriting company listed above detail exclusions, limitations, reductions of benefits and terms under which the policies may be continued in force or discontinued. This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or alters the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. Benefits are subject to state availability. © 2020 The Hartford.

The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation process, please review our website: <http://thehartford.com/group-benefits-producer-compensation>. Disability Form Series includes GDB-1000, GED-1200, or state equivalent.

5/9/20 NS 05/21

BASIC GROUP TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS



More than half of Americans
(53%) expressed a
heightened need for life
insurance because of
COVID-19.¹

Town of Rocky Hill - Town Employees

The group term Life and Accidental Death and Dismemberment (AD&D) insurance available through your employer gives extra protection that you and your family may need. Life and AD&D insurance offers financial protection by providing you coverage in case of an untimely death or an accident that destroys your income-earning ability. Life benefits are disbursed to your beneficiaries in a lump sum in the event of your death.



To learn more about Life and AD&D insurance, visit thehartford.com/employee-benefits/employees

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE	AD&D COVERAGE
Employee	Benefit: \$20,000	AD&D: Included

AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT

Covered accidents or death can occur up to 365 days after the accident. The total benefit for all losses due to the same accident will not exceed 100% of your coverage amount.

LOSS FROM ACCIDENT	COVERAGE
Life	100%
Both Hands or Both Feet or Sight of Both Eyes	100%
One Hand and One Foot	100%
Speech and Hearing in Both Ears	100%
Either Hand or Foot and Sight of One Eye	100%
Movement of Both Upper and Lower Limbs (Quadriplegia)	100%
Movement of Both Lower Limbs (Paraplegia)	75%
Movement of Three Limbs (Triplegia)	75%
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	50%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Movement of One Limb (Uniplegia)	25%
Thumb and Index Finger of Either Hand	25%

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee who are subject to Collective Bargaining Agreement Excluding ABPO Local 316 Police who works at least 30 hours per week on a regularly scheduled basis.

AM I GUARANTEED COVERAGE?

If your coverage amount exceeds \$20,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

AD&D is available without having to provide information about your health.

WHEN CAN I ENROLL?

Your employer will automatically enroll you for this coverage. If you have not already done so, you must designate a beneficiary.

WHEN DOES THIS INSURANCE BEGIN?

This insurance will become effective for you on the date you become eligible.

You must be actively at work with your employer on the day your coverage takes effect.

WHEN DOES THIS INSURANCE END?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this life coverage with you. Coverage may be continued for you under a group portability certificate or an individual conversion life certificate. The specific terms and qualifying events for conversion and portability are described in the certificate. Conversion and portability are not available for AD&D coverage.

¹LIMRA, Facts About Life 2020. <https://www.limra.com/globalassets/limra/newsroom/fact-tank/fact-sheets/limra-facts-2020-final.pdf>, as viewed on October 14, 2020.

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The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding The Hartford's compensation practices, please review our website <http://thehartford.com/group-benefits-producer-compensation>. Life Form Series includes GBD-1000, GBD-1100, or state equivalent 5962a and 5962b NS 07/21

LIMITATIONS & EXCLUSIONS



This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- You must be a citizen or legal resident of the United States, its territories and protectorates.

5962a NS 05/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Exclusions: (Applicable to all benefits except the Life Insurance Benefit and the Accelerated Benefit) What is not covered under The Policy?

- The Policy does not cover any loss caused or contributed to by:
 - anaphylactic shock;
 - any form of auto-erotic asphyxiation;
 - failure to wear a Seat Belt while driving or riding as a passenger in a Motor Vehicle;
 - intentionally self-inflicted Injury;
 - stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis or aneurysm;
 - suicide or attempted suicide, whether sane or insane;
 - war or act of war, whether declared or not;
 - injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority except Reserve or National Guard Service;
 - injury sustained while On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
 - injury sustained while On any aircraft:
 - as a pilot, crewmember or student pilot;
 - as a flight instructor or examiner;
 - if it is owned, operated or leased by or on behalf of the Policyholder, or any Employer or organization whose eligible persons are covered under The Policy; or
 - being used for tests, experimental purposes, stunt flying, racing or endurance tests;
 - injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician
 - injury sustained while riding or driving in a scheduled race or testing any Motor Vehicle on tracks, speedways or proving grounds;
 - injury sustained while committing or attempting to commit a felony;
 - injury sustained while Intoxicated;
 - injury sustained while driving while Intoxicated;
 - injury sustained by illegal fireworks or the use of any legal fireworks when not following the manufacturer's lighting instructions;
 - driving and violating any applicable cellular device use or distracted driving laws; or
 - failure to wear a helmet while On or riding as a passenger On a motorcycle, bicycle, all-terrain vehicle (ATV) or any other type of motor bike.
- You must be a citizen or legal resident of the United States, its territories and protectorates.

DEFINITIONS

- Loss means, with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to sight, speech or hearing, entire and irrecoverable loss thereof; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints; with regard to movement, complete and irreversible paralysis of such limbs.
- Injury means bodily injury resulting directly from an accident, independent of all other causes, which occurs while you have coverage.

5962c NS 05/21 Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.

GROUP LONG TERM DISABILITY INSURANCE

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS

- You must be under the regular care of a physician to receive benefits.
- You cannot receive disability insurance benefit payments for disabilities that are caused or contributed to by:
 - War or act of war (declared or not)
 - The commission of, or attempt to commit a felony
 - An intentionally self-inflicted injury
 - Your being engaged in an illegal occupation

PRE-EXISTING CONDITIONS

- Your insurance excludes the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your certificate, you will be covered for a disability due to that condition only if:
 - You have not received treatment for your condition for 3 months before the effective date of your insurance, or
 - You have been insured under this coverage for 12 months prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
 - You have already satisfied the pre-existing condition requirement of your previous insurer

LIMITATIONS

- Mental Illness and Substance Abuse Limitation.** If you are disabled because of Mental Illness or because of alcoholism or the use of narcotics, sedatives, stimulants, hallucinogens or other similar substance, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.

OFFSETS

- Your benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:
 - Social Security disability insurance (please see next section for exceptions)
 - Workers' compensation
 - Other employer-based insurance coverage you may have
 - Unemployment benefits
 - Settlements or judgments for income loss
 - Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Your benefit payments will not be reduced by certain kinds of other income, such as:
 - Retirement benefits if you were already receiving them before you became disabled
 - Retirement benefits that are funded by your after-tax contributions your personal savings, investments, IRAs or Keoghs profit-sharing
 - Most personal disability policies
 - Social Security cost-of-living increases

This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the Policy:

Insured's monthly [Pre-Disability Earnings/Basic Monthly Pay] \$3,000
Long term disability benefits percentage x 60%
Unreduced maximum benefit \$1,800
Less Social Security disability benefit per month - \$900
Less state disability income benefit per month - \$300
Total amount of long term disability benefit per month \$600

THIS POLICY PROVIDES LIMITED BENEFITS.

This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.

In New York: This Disability policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

5962d NG 05/01 Disability Form Series includes GDD-1099, GPD-1200, or state equivalent.

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BENEFICIARY DESIGNATION



Initial Beneficiary Designation(s) OR Change of all prior beneficiary designation(s) (check only one box), I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Employee Address:		Telephone Number: ()
Policyholder/Employer:		Policy Number:

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)		
Name: _____	Date of Birth: _____	
Address: _____	Telephone Number: ()	
Social Security Number: _____	Relationship: _____	Benefit Percent: _____ %
Name: _____	Date of Birth: _____	
Address: _____	Telephone Number: ()	
Social Security Number: _____	Relationship: _____	Benefit Percent: _____ %
Name: _____	Date of Birth: _____	
Address: _____	Telephone Number: ()	
Social Security Number: _____	Relationship: _____	Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)		
Name: _____	Date of Birth: _____	
Address: _____	Telephone Number: ()	
Social Security Number: _____	Relationship: _____	Benefit Percent: _____ %
Name: _____	Date of Birth: _____	
Address: _____	Telephone Number: ()	
Social Security Number: _____	Relationship: _____	Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)

BENEFICIARY DESIGNATION FORM INSTRUCTIONS



You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%
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Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Does	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**