GROUP BENEFITS

Ackerman Security Systems Benefits Enrollment Form

THE HARTFORD

Information About You

Name: Matthew W. Autry. 36229-0	**Social Security Number** 254451830
Date of Birth: 12 27 1968	**Date of Hire:** 06 25 2007
Earnings:	**Job Description:**

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 employer's contract.*

Voluntary Long Term Disability Insurance

You have the opportunity to enroll in Voluntary Long Term Disability Insurance. Voluntary Long Term Disability 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 180 days. This plan provides you with income protection to replace up to 60% of your Earnings, to a maximum monthly benefit of $5,000 for the first 24 months. After that, the benefits may reduce to 20% of your Earnings. If you are electing coverage for the first time you will be required to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective. If you are currently enrolled, evidence of insurability is not required to maintain your current 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+
Rate	0.1210	0.1050	0.2490	0.3490	0.3890	0.6300	0.8560	1.0040	0.8350	0.6390	0.6390	0.6390

To calculate your Monthly cost, please use the following formula(s):

_____ ÷ 12 = _____ ÷ 100 = _____ x _____ = $_____

Your Annual Earnings Maximum = $100,000 | Your Monthly Earnings | Rate | My Monthly Cost

☐ I elect to **purchase** Long Term Disability coverage.
☐ I **decline** to purchase Long Term Disability coverage.
☐ I elect to **continue** my current coverage.

Voluntary Short Term Disability Insurance

You have the opportunity to enroll in Voluntary Short Term Disability Insurance. Voluntary Short Term Disability Insurance helps to replace your income if you are sick or injured and cannot work. This coverage begins on the 8TH day of accident and 8TH day of illness and is designed to continue for a period of 25 weeks and provides income protection to replace up to 60% of your Earnings, to a maximum weekly benefit of $1,000. If you are electing coverage for the first time you will be required to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective. If you are currently enrolled, evidence of insurability is not required to maintain your current 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+
Rate	0.8500	0.9000	0.8200	0.6800	0.7400	0.7800	0.9000	1.2300	1.6500	1.7800	1.7800	1.7800

To calculate your Monthly cost, please use the following formula(s):

_____ ÷ 52 = _____ x 60% = _____ ÷ 10 = _____ x _____ = $_____

Your Annual Earnings | Your Weekly Earnings | Weekly Benefit Max = $1,000 | Rate | My Monthly Cost

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Ackerman Security Systems
Generic EP Full Language

Prepare Today.
Help Protect Tomorrow.

Name: Matthew W. Autry.

☐ I elect to **purchase** Short Term Disability coverage.
☐ I **decline** to purchase Short Term Disability coverage.
☐ I elect to **continue** my current coverage.

Basic Life and AD&D Insurance

You can purchase Basic Life and AD&D Insurance in an amount equal to $20,000.

☐ I **elect** to purchase Basic Life and AD&D coverage at a monthly cost of $4.88. ☐ I **decline** to purchase Basic Life and AD&D coverage.

Supplemental Life Insurance

You can purchase Supplemental Life Insurance in increments of $10,000. The maximum amount you can purchase cannot be more than 5 times your annual Earnings or $500,000. If you are currently participating in this coverage you may increase your current coverage by $10,000, not to exceed $50,000, without providing evidence of good health. If you are electing coverage for the first time, you may elect coverage in the amount of $10,000. Additional coverage amounts will require evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

Have you smoked a cigarette, cigar, used pipe or chewing tobacco, nicotine chewing gum or snuff during the 12 months prior to today's date? If YES, use The Tobacco User cost below; if No, use the Non Tobacco User cost below:

☐ **Yes** ☐ **No**

Non Tobacco User

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.1100	0.1100	0.1150	0.1510	0.2100	0.3320	0.5120	0.8420	1.2710	2.2080	3.9380	7.9250

Tobacco User

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.1630	0.1630	0.1720	0.2430	0.3700	0.5800	0.9850	1.3990	1.9790	3.2750	5.6880	10.2250

To calculate your Monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $_____
Life Benefit Amount — Rate — My Monthly Cost

☐ I elect to **purchase** $_____ of Life coverage.
☐ I **decline** to purchase Life coverage.
☐ I elect to **continue** my current Life coverage.

Spouse Supplemental Life Insurance

If you purchase Supplemental Life Insurance, you can purchase Spouse Supplemental Life Insurance in increments of $5,000. The maximum amount you can purchase cannot be more than the lesser of $250,000 or 100% of your Employee Voluntary/Supplemental Life Insurance coverage. If you are currently participating in this coverage you may increase your current coverage by $5,000, not to exceed $25,000 without providing evidence of insurability. If you are electing coverage for the first time, you may elect coverage in the amount of $5,000. Additional coverage amounts will require your Spouse to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

Costs are based on spouse's age.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.1080	0.1080	0.1140	0.1560	0.2240	0.3480	0.5480	0.8360	1.4500	2.4540	4.3220	8.5760

To calculate your Monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $_____
Life Benefit Amount — Rate — My Monthly Cost

☐ I elect to **purchase** $_____ of Life coverage.
☐ I **decline** to purchase Life coverage.
☐ I elect to **continue** my current Life coverage.

First Name	Last Name	Gender	Date of Birth	Date of Marriage

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Name: Matthew W. Autry.

Child(ren) Supplemental Life Insurance

If you purchase Supplemental Life Insurance, you can purchase Child(ren) Supplemental Life Insurance for your Dependent Child(ren) between the ages of 15 days and 19 years (26 years if a full time student), in increments of $2,000. The maximum amount you can purchase cannot be more than $10,000. Child(ren) between the ages of 15 days and 6 months are limited to coverage in the amount of $1,000.

To calculate your Monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x $0.2700 = $_____

Life Benefit Amount | Rate | My Monthly Cost

☐ I elect to **purchase** $_____of Life coverage.
☐ I **decline** to purchase Life coverage.
☐ I elect to **continue** my current Life coverage.

First Name	Last Name	Date of Birth	Gender

Family Voluntary Accidental Death & Dismemberment Insurance

You can purchase Family Voluntary Accidental Death & Dismemberment Insurance in increments of $10,000. The maximum amount you can purchase cannot be more than the lesser of 5 times your annual Earnings or $500,000.

You can also purchase coverage for your Spouse or Child(ren) at the percentages of your election outlined in the following chart:

Family Member(s) Covered:	Employee Only	Employee & Spouse Only	Employee & Child(ren) Only	Employee, Spouse & Child(ren)
Percent of Benefit Paid:	**100%**	**100% for Employee 50% for Spouse**	**100% for Employee 15% for each Child**	**100% for Employee 40% for Spouse 10% for each Child**

Coverage Option:	Rate
Myself Only	**$0.0500**
Myself and My Family	**$0.0680**

To calculate your Monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $_____

Elected Benefit Amount (Employee Coverage Amount Only) | Rate | My Monthly Cost

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Name: Matthew W. Autry.

- ☐ I elect to **purchase** $_____of AD&D coverage for myself only.
- ☐ I elect to **purchase** $_____of AD&D coverage for myself. My family will be covered at the percentages of my election listed above.
- ☐ I **decline to purchase** AD&D coverage.
- ☐ I elect to **continue** my current coverage.

Beneficiary Designation

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. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

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. Please provide **all** of the information requested below. 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 benefits administrator or your own legal advisor.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your spouse and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, 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. Disclaimer: Spousal consent does not apply to ERISA plans.

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 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: _____

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life, Disability, and Accident Insurance coverage described in the Benefit Highlight Sheets and offered through Ackerman Security Systems.

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 employer) 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 authorize my employer to make the appropriate payroll deductions from my earnings.

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 employer. 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.

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Name: Matthew W. Autry.

Signed _____ Date _____

Please print, sign, then scan and submit an electric copy or hand deliver to HR.

Print & Submit **Reset**

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