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ADD-4223

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE ENROLLMENT FORM

Complete all information in ink.

1 Complete information:

Name:______________________________

Address:______________________________

City:______________________________

State:____________________ZIP:__________

MOAA Member Number:______________________________

E-mail Address:______________________________
(Optional. MOAA will not rent or sell your e-mail address.)

Endorsed by:

Underwritten by:
Hartford Life Insurance Company
Simsbury, CT 06089

2 Check coverage desired:

$500,000.00 Benefit Amount	❒ Member & Family (00K3)	❒ Member Only (00K1)
$250,000.00 Benefit Amount	❒ Member & Family (00E3)	❒ Member Only (00E1)
$200,000.00 Benefit Amount	❒ Member & Family (00D3)	❒ Member Only (00D1)
$150,000.00 Benefit Amount	❒ Member & Family (00C3)	❒ Member Only (00C1)
$100,000.00 Benefit Amount	❒ Member & Family (00B3)	❒ Member Only (00B1)

Note: If you select family coverage, the benefit amounts for your spouse and children are reduced based on your family status. Please see Plan Information for details.

Your coverage will reduce by 50% at age 70, an additional 50% at age 75, and final 50% at age 80. The maximum amount of coverage available at age 80 is $25,000.00

3 Please fill in information:

Date of Birth: ______/______/______ (mo day yr)   Sex: ❒ Male ❒ Female

Rank:______________________________

Service:______________________________

Your beneficiary for this coverage will be your legal spouse, if living. If you have no spouse, your beneficiary will be your children, your parents, your brothers and sisters, or your estate, in that order. The member is the beneficiary for spouse and children's coverage. If you wish to make other beneficiary arrangements, please contact the plan administrator.

4 Sign and date below:

I hereby enroll with Hartford Life Insurance Company of Simsbury, Connecticut, for coverage under the MOAA Accidental Death and Dismemberment Plan. I certify that I am a member of MOAA and I have read and understand the conditions and exclusions of the program. I understand that my coverage will become effective upon the first day of the month following the administrator's receipt of this Enrollment Form and my first annual premium payment.

Member's Signature X______________________________ **Date** X__________

Don't send money now! You'll be billed later.

Mail your completed Enrollment Form to:
MOAA Insurance Plans • P.O. Box 14464 • Des Moines, IA 50306

Questions? Call Toll-Free **1-800-247-2192**

(Hearing-impaired or voice-impaired members may call the Relay Line at 1-800-855-2881.)

Or, e-mail moaa@marshpm.com

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