HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

MARINE CORPS ASSOCIATION EST 1913

THE HARTFORD

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN (AD&D) ENROLLMENT FORM

RETURN FORM TO ACTIVATE COVERAGE — ENCLOSE YOUR CHECK FOR YOUR FIRST PREMIUM PAYMENT TO:
MCA GROUP INSURANCE PROGRAM
1200 E. GLEN AVE. PEORIA HEIGHTS, IL 61616-5348

1. I WANT TO ENROLL IN THE MCA ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN.

Fill in one circle and enclose a check for this amount. For your convenience, after your initial payment, your monthly payment will be automatically deducted from your checking account.

*At age 70, all coverage is reduced by 50% and will be further reduced by 50% at age 75

	ANNUAL RATES*			
BENEFIT AMOUNT*	MEMBER ONLY	MEMBER & SPOUSE	MEMBER & CHILDREN	FAMILY
$100,000	❍ $66	❍ $99	❍ $74	❍ $99
$200,000	❍ $132	❍ $198	❍ $148	❍ $198
$300,000	❍ $198	❍ $297	❍ $222	❍ $297
$400,000	❍ $264	❍ $396	❍ $296	❍ $396
$500,000	❍ $330	❍ $495	❍ $370	❍ $495

2. PLEASE COMPLETE

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zipcode _____

Date of Birth (MM/DD/YY) _____ Phone Number _____

Sex: ❍ Male ❍ Female Email Address _____

3. PLEASE COMPLETE FAMILY INFORMATION (IF ENROLLING IN FAMILY COVERAGE)

Spouse Name (Last, First, Middle Initial) _____ Date of Birth (MM/DD/YY) _____ Sex: ❍ M ❍ F

Child Name: _____ Date of Birth (MM/DD/YY) _____ Sex: ❍ M ❍ F

Child Name: _____ Date of Birth (MM/DD/YY) _____ Sex: ❍ M ❍ F

Child Name: _____ Date of Birth (MM/DD/YY) _____ Sex: ❍ M ❍ F

4. PLEASE READ, THEN SIGN BELOW AND RETURN TO ENROLL.

I hereby enroll with Hartford Life and Accident Insurance Company of Hartford, CT, for coverage under the Accidental Death and Dismemberment Plan, ADD-13269. 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 premium payment.

Member's Signature X _____ **Date** (MM/DD/YY) _____

COMPLETE THIS FORM. THEN MAIL IN FORM WITH YOUR FIRST PAYMENT.

Policy No. ADD-13269

Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.
221585-MCA-ADD-APP