Educator Disability Enrollment/Change Request Form NJ

Hartford Life Insurance Company

c/o MGM Benefits Group
2121 N. Glenville Drive
Richardson, Texas 75082
Fax: 972.881.2251

Effective Date	Policy Number

Benefit Coverage

☐ Initial Enrollment
☐ New Hire
☐ Annual Enrollment
☐ Change Request –

If Change, type of change:

☐ *Class Change*
☐ *Name Change*
☐ *Address Change*
☐ *Salary Change*

Select Coverage (the coverage you choose will replace all prior coverage amounts you have under this policy):

Choose Plan: ☐ Platinum ☐ Gold ☐ Bronze

Choose Elimination Period: ☐ 7 days ☐ 14 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Choose Monthly Benefit Amount: You may not purchase more than the maximum monthly benefit amount. If your maximum monthly benefit is not shown, use the next lower earnings and benefit amount.

Monthly Benefit Amount $_____ Your Cost $_____

Payroll Deduction Mode: ☐ 10 Deductions ☐ 12 Deductions ☐ Other: _____

What portion of your premium is board paid (if any)? $_____

Employer Name			
Employee Name (Last, First, Middle Initial)		**Social Security Number**	
Employee Home Address			
City		**State**	**Zip**
Date of Birth	**Gender** ☐ **Male** ☐ **Female**	**Phone** ☐ **Home** ☐ **Work**	
E-Mail Address		**Employee Class (if applicable)**	
Occupation	**Hours Worked/Week**	**Annual Earnings**	**Date of Hire**

Employee Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage described in the Benefit Highlight Sheet and offered through my school district. 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.

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.

My signature below signifies my agreement with the statements and authorization above.

Employee Signature	Date
X	

Please keep original enrollment form for your records, copy should be sent to MGM Benefits Group by mail, fax or through your Broker.