

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)



The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Group Retiree Health Insurance – GRIP (The Hartford’s Group Retiree Insurance Plan®) Enrollment Form
For Initial Enrollment and Subsequent Changes

Policyholder: United Food & Commercial Workers Union, Local 99 Policy Number(s): AGP-

Please print clearly in ink or type

Retiree’s Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Medicare/HIC # _____

Phone Number: _____ Email Address: _____

Gender Male Female Date of Birth _____ Social Security # _____

Date of Retirement _____ Have you enrolled in Medicare Part B? Yes No

If no, when do you intend to enroll? _____

Spouse’s Name (Only if enrolling): _____
First Middle Last

Gender Male Female Date of Birth _____ Social Security # _____

Medicare/HIC # _____ Date of Retirement _____

Has your spouse enrolled in Medicare Part B? Yes No

If no, when does he/she intend to enroll? _____

To the best of your knowledge:

Do you or your spouse, if enrolling, have any other health insurance including an employer health plan?

Retiree Yes No **Spouse** Yes No

If so, please provide the information requested below:

Covered Person	Company Name	Policy Number	Kind of Policy	Effective Date	Expiration Date

2. If the answer to question 1 is yes, do you or your spouse, if enrolling intend to replace these medical or health policies with this policy or certificate? **Retiree** Yes No **Spouse** Yes No

If yes, for what reason are you (or your spouse, if enrolling) replacing the coverage?

- Additional Benefits
- Fewer benefits and lower premiums
- Integration with Medicare
- No change in benefits, but lower premiums
- Other (please specify) _____

3. Are you covered by Medicaid?
Retiree Yes No **Spouse** Yes No

Please Add Coverage Effective Date and Check Desired Plan to Enroll:

	Requested Effective Date	Plan 1	Plan 2	Plan 3
Retiree				
Spouse				

Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance offered by the Policyholder. I understand and agree that if I decline insurance now, I may not be able to enroll in the future.

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 can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

Fraud Notice(s)

For Residents of Florida:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Louisiana:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New York:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Virginia:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Date: _____ Retiree Signature: _____

Date: _____ Spouse Signature: _____

(if enrolling)