ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PLAN

Enrollment Form

MarineCorps Association & Foundation

Advancing Leadership and Recognizing Excellence Since 1913

Policyholder: Marine Corps Association & Federation
Underwritten by: Hartford Life and Accident Insurance Company, Hartford, CT 06155

Please print. Use dark ink. Do not erase. Initial changes. Send in payment with this form.

Member:

Member Name:
(FIRST, MIDDLE, LAST)

Address:

City: State: Zip: Birth Date: / / Sex: ○ Male ○ Female

Email:

I hereby apply for the following coverage: ○ Member Only ○ Member & Family ○ $100,000 (100691) ○ $200,000 (100692)

Benefits reduce by 50% at age 70. At age 75, benefits reduce by another 50%. Rates and/or benefits may be changed on a class basis.

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.

Spouse: *(if enrolling)*

Spouse Name:
(FIRST, MIDDLE, LAST)

Spouse's Date of Birth: / / Spouse benefits are limited to 50% of the Member's benefit level.

Your first payment must accompany this enrollment form. Make your check payable to MCA&F Group Benefit Program.

Authorization:

I hereby enroll with Hartford Life and Accident Insurance Company of Hartford, CT, for coverage under the Accidental Death and Dismemberment Plan, Policy Number ADD-11116.

I understand that my coverage will become effective on the first day of the month following receipt of this Activation form and my first month's premium payment. I further understand that I am eligible to apply for these coverages as long as I am an MCA&F Member, reside in the U.S., under age 70 and coverage will terminate once I reach age 80.

I authorize the Administrator to initiate credit card payments or debit entries for my regular payment from the credit card or bank account provided above. I understand that payment will be processed on or after the due date and will continue to be charged or deducted from my account unless I notify the Administrator otherwise in writing or my coverage ends. I also understand if corrections of the debit are necessary, this may involve an adjustment to my account.

✗ Member's Signature (Required) — / / Today's Date *(MM/DD/YYYY) (Required)*

✗ Spouse's Signature (Required if enrolling) — / / Today's Date *(MM/DD/YYYY) (Required if enrolling)*

Please mail your signed Enrollment Form and Payment to:
MCA&F Group Benefit Program, P.O. Box 26610, Phoenix, AZ 85068-6610

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Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.

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