EMPLOYER INFORMATION DATA FORM

Instructions to Producer:

If you are completing the Employer Information Section on behalf of your client, please use the following list as a reference to the type of information you will need. Once the Employer Information Section is completed online, The Hartford will send an email to the employer to electronically sign the necessary documents. You will also receive a notification email.

If the employer is completing the Employer Information Section online, you may want to provide this list so that they are aware of the information required before proceeding.

POLICY HOLDER INFORMATION

Legal Employer Name: _____

Legal Address: *(cannot be a PO Box)* _____

City: _____ State: _____ Zip: _____ SIC Code: _____

Type of Legal Entity: *(please check one)*

☐ Corporation ☐ S Corporation ☐ Partnership ☐ Non-Profit Organization
☐ Sole Proprietor ☐ Limited Partnership ☐ LLC

Federal Tax ID Number: _____ Nature of business: _____

Check box if mailing address is same as above. ☐ If different:

Mailing Address: _____ City: _____ State: _____ Zip: _____

Authorized Employer Representative:

☐ Mr. ☐ Ms. ☐ Dr. First Name: _____ Last Name: _____

Title: _____ Phone Number (_____)_____-_____

Fax Number: (_____)_____-_____

Authorized Employer Representative's Email address_____

Billing:

Check Box if billing address is same as above. ☐

Billing Contact Name: _____ Billing Contact Email:_____

Billing Address 1:_____ Billing Address 2: _____

Billing City: _____ Billing State: _____ Billing Zip: _____

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POLICY PROVISION

Benefit Change Date: Age, Class and Earnings changes are effective on the Plan's October 1st anniversary date.

Original Employee Waiting Period: On the policy effective date.

New Hire Waiting Period: New hire eligibility waiting period for coverage is: (select one)

- ☐ Date of hire
- ☐ First of Month following date of hire
- ☐ First of Month following 30 days after date of hire
- ☐ First of Month following 60 days after date of hire
- ☐ First of Month following 90 days after date of hire
- ☐ First of Month following 180 days after date of hire

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Is this group plan an ERISA plan? ☐No ☐ Yes If yes, ERISA Plan Number: _____
(If unknown, will default to 501)

Plan Records: The Employer's Fiscal Year will be noted as January 1.
If other than the month of January: _____. The date will always be the first of the month.

LIFE AND AD&D

Will this Life and AD&D plan be replacing an existing Life and AD&D plan? ☐ No ☐ Yes
If yes: Name of Carrier: _____

Beneficiary Proceeds Option: Beneficiaries receive proceeds via lump sum check.

VOLUNTARY LIFE AND AD&D

Will this Voluntary Life and AD&D plan be replacing an existing Voluntary Life and AD&D plan? ☐ No ☐ Yes
If yes: Name of Carrier: _____

Domestic Partner Coverage: Domestic partner coverage is included in the life insurance plan, except for residents of Louisiana and situs state employers of Louisiana.

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LONG-TERM DISABILITY

Will this new LTD plan be replacing an existing LTD plan? ☐ No ☐ Yes If Yes, Name of Carrier_____
Note: The Hartford will need a copy of the employer's current carrier LTD booklet.

W-2 Services

The employer elects W-2 and FICA Match services *(The employer cannot elect FICA Match services, without electing W-2 services.)* ☐ No ☐ Yes
(If selecting yes, please inform the employer that they are authorizing the carrier to prepare Forms W-2 for payees and file such forms with the appropriate United States Federal and State agencies. They are also authorizing the carrier to report and deposit the Employer share of any FICA tax withheld from benefits paid.)

W-2 and FICA Match services selected above apply to all locations, divisions and/or classes of the Policyholder.
☐ No ☐ Yes
If no, the Policyholder must provide a listing of all locations, divisions and/or classes that will have Tax Services that differ from the selection under Section B of this agreement:

Company Name	Class	City	State	Division	Number of Employees

Do you allow your employees to elect to include the cost of Long Term Disability coverage in taxable income ("gross up")? □ No □ Yes If yes, please specify which class or classes:

SHORT-TERM DISABILITY

Will this STD plan be replacing an existing Short-Term Disability plan? ☐ No ☐ Yes
If Yes, Name of Carrier_____

W-2 Services

I elect W-2 services to have the carrier prepare W-2 for payees and files such forms with the appropriate United States Federal and State Agencies. ☐ No ☐ Yes If yes, your authorization(s) for W-2 services apply to the following plan(s):
☐ Fully Insured STD

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W-2 services selected above apply to all locations, divisions and/or classes of the Policyholder. ☐ No ☐ Yes
If no, the Policyholder must provide a listing of all locations, divisions and/or classes that will have Tax Services that differ from the Employer's situs state:

Company Name	Class	City	State	Division	Number of Employees

CRITICAL ILLNESS

Will this Critical Illness plan be replacing an existing Critical Illness plan? ☐ No ☐ Yes
If Yes, Name of Carrier_____

HOSPITAL INDEMNITY

Will this Hospital Indemnity plan be replacing an existing Hospital Indemnity plan? ☐ No ☐ Yes
If Yes, Name of Carrier_____

ACCIDENT

Will this Accident plan be replacing an existing Accident plan? ☐ No ☐ Yes
If Yes, Name of Carrier_____

If a Producer, please login to the Small Business Quoting Platform to complete this section.

If an employer, please refer to the email received from The Hartford for instructions.