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

THE HARTFORD

Accidental Death Insurance Plan Enrollment Form

ALA Allegiance Accident Insurance Plan *Exclusively for ALA Members*
YOU CANNOT BE TURNED DOWN

Policy Number: ADD-13256 American Legion Auxiliary (ALA)

1 Member Information

☐ Are you a Member of the American Legion Auxiliary?

American Legion Auxiliary Membership Number:

Your Name

Gender: ☐ Male ☐ Female

____/____/____
Your Date of Birth

Home Address (Street, City, State, Zip)

Phone Number

Email Address
(For internal use only for important updates & member bulletins)

2 Coverage Information
Accidental Death Insurance

Please refer to the charts in the enclosed brochure for coverage details in order to make your selection and determine payment due.

Individual: ☐ **Semi - Annually $32.50** ☐ **Annually $65.00**
Family: ☐ **Semi - Annually $52.00** ☐ **Annually $104.00**

Family coverage is a percentage of your coverage.

3 Payment Options

Automatic Bank Withdrawal (Electronic Funds Transfer):

Name:

Banking Institution Routing Number

Account Number
Bank Account Type: ☐ Checking ☐ Savings

For your convenience you will be billed quarterly.

I authorize the Administrator to initiate debit entries for my regular payment from the 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.

X
Member Signature Date

Mail your completed enrollment form to:
Amwins Group Benefits, LLC.
Member Benefit Provider for the American Legion Auxiliary
PO BOX 152501 IRVING TX 75015-9802
Please mail within 10 days
Questions? Call **1-844-363-1726**

4 Confirmation

I acknowledge that I have been given the opportunity to enroll in the ALA Allegiance Accident Insurance Plan. I certify that I am an American Legion Auxiliary Member and that the above information is true and complete to the best of my knowledge.

I understand and agree that insurance will go into effect upon receipt of my first premium payment and this form 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 American Legion Auxiliary 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.

I wish to enroll in the ALA Allegiance Accident Insurance Plan. The family plan protects at a percentage of my coverage amount. Yes, by all means, I want to start enjoying the insurance coverage. Please send me my Certificate of Insurance reflecting the coverage available to me as a [_] year(s) Member

X
Member Signature Required Date

AMERICAN LEGION AUXILIARY

AMWINS GROUP BENEFITS
A Member Benefit Provider for the American Legion Auxiliary

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 Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

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 Jersey:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

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:
Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.