



**SECTION 1**

<input type="checkbox"/> New <input type="checkbox"/> Change (check each section applicable) _____ (enter certificate # if making a change)	Policy/Group #: <b>681091 / DEN1</b>
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**SECTION 2**  Change

**EMPLOYER INFORMATION**

Do you work in the Federal Judiciary? <input type="checkbox"/> Yes <input type="checkbox"/> No	Department (see reverse for code)	Agency (Executive Branch use ONLY)
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For Federal Judiciary Use Only

Circuit:	District of:	Court:	Are you a judge? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**SECTION 3**  Change

**PERSONAL INFORMATION**

Social Security Number	Name (last, first, middle initial)		
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married	Street Address		
Date of Birth / /	City	State	Zip Code
Home Telephone	Work Telephone	Date of Hire / / Month Day Year	E-mail Address

**SECTION 4**  Change

**COVERAGE INFORMATION**

I am paid: <input type="checkbox"/> bi-weekly (26 pay periods per year) <input type="checkbox"/> monthly (12 pay periods per year)	<b>Please confirm your eligibility:</b> I am an active full-time employee of the United States Federal Government working at least 20 hours per week. <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify number of hours worked per week _____
Plan Coverage	<input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family

**SECTION 5**  Change

**BENEFICIARY INFORMATION**

Primary Beneficiary Name Last Name First Name	Relationship of Beneficiary	Social Security Number / Tax ID# (if trust or charity)
Street Address	City	State Zip
Contingent Beneficiary Name Last Name First Name	Relationship of Beneficiary	Social Security Number
Street Address	City	State Zip

**SECTION 6**  Change

**DEPENDENT COVERAGE INFORMATION**

Last Name	First Name	M.I.	Gender	Date of Birth	Social Security Number
<b>SPOUSE:</b>					
<b>CHILDREN:</b>					

**SECTION 7**

I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in any communication materials provided me and/or the certificate issued to me. I understand that the effective date of insurance for myself is subject to my being actively at work on that date. I request arrangement for the issuance of Group Accident Insurance, underwritten by The Hartford Life and Accident Insurance Company, for which I am or may become eligible and authorize deductions of the required contributions from my earnings. My signature below signifies my agreement with the statements and authorization above.

**NOTE: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO 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.**

Employee Signature	Date
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After completion, **sign and date the form on where indicated.**  
Make a copy for your records and **Fax to Dennis Stephens, CLU at 888-334-5809**