JJF Management Services, Inc.

Enrollment For
Group Life & AD&D, LTD
Optional Life

SECTION I - APPLICANT INFORMATION

Name and Address:	Date of Birth	SSN	Salary
	Date of Hire	Age	Hours Worked	Class
	Effective Date	Location	

SECTION II - BENEFIT SELECTION

ACCEPT DECLINE — *Check the boxes that apply for all products:*

Basic Term Life & AD&D — Life Insurance replaces your income and helps your family survive after your death. The Basic Term Life & AD&D is paid for by your employer.

[X] [ ] $

Optional Life — Optional Life allows you to expand and enhance your benefits through convenient payroll deduction. Optional Life gives you the opportunity to purchase life insurance coverage for yourself at a fraction of what insurance would cost in the individual marketplace. Employees electing amounts of $50,000 and over will require an evidence of insurability form to be completed.

You may elect increments of $10,000 to a maximum of $200,000. You can elect one of the following benefit amounts.

Accept	Decline	Coverage Amount	$20,000	$50,000	$		
[ ]	[ ]	Monthly Premium	[ ]	[ ]	[ ]	[ ]	

SECTION III - BENEFICIARY INFORMATION

It is important that your beneficiary designation is clear. It is also important that you name a primary beneficiary and contingent beneficiary. If the beneficiary is not related to you by either blood or marriage, please insert the words 'Not Related' in the relationship box.

Primary	Full Name	Address	Relationship	D.O.B	%
Contingent					

SECTION IV - ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

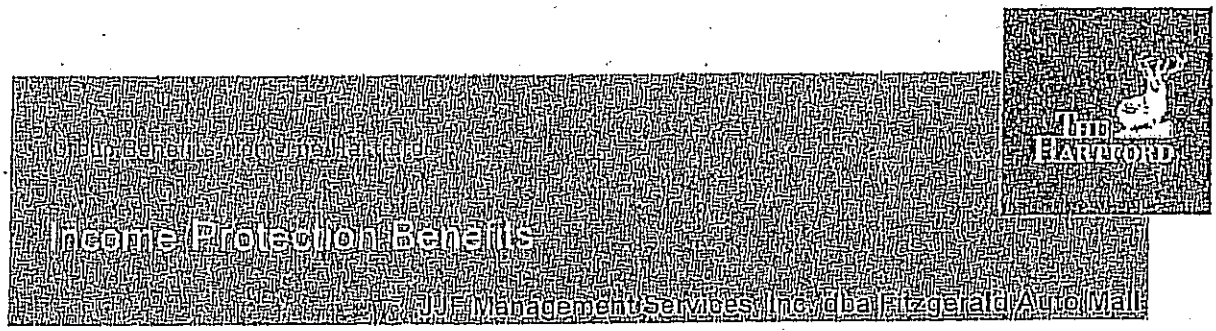
I have been given the opportunity to enroll in JJF Management Service's benefit coverage's. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the insurer and understand my request for coverage may be denied. Current employees who did not previously enroll will be required to provide evidence of insurability.

I request to be insured and authorize payroll deductions to cover the cost of such insurance. Information in this application, including the insurability Questionaire, is given to obtain insurance and the statements and answers are represented, to the best of my knowledge and belief to be true and complete. I understand that (a) the insurance applied for shall not take effect until the application is approved; and (b) all insurance is subject to the eligibility provisions of the policy; and (c) must be actively at work (as defined in the group policy) to be insured. If I am not actively at work on the date my coverage would become effective, my coverage will not begin until the day I return to work. I also understand that a pre-existing condition exclusion may apply to my coverage.

If your answers on this application are incorrect or untrue, the carrier has the right to deny benefits or rescind your coverage.

Authorization to Release Information: I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau (MIB) or any other organization, institution or person that has any records of knowledge of me or my health to give The Hartford or its reinsurer(s) any such information. This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original.

Employee Signature _____ *Date* _____



Information About You

Benefits Enrollment Form

Name: 24234-0	Social Security Number / Employee ID Number:
Date of Birth:	Date of Hire:
Earnings:	Location/Department/Division:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- Step 1: Please enter or check your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer's contract.*
- Step 2: Please sign, date and return this form to Martha Kowalski.

Supplemental Life Insurance

You can purchase Supplemental Life Insurance in increments of $10,000. The maximum amount you can purchase cannot be more than $200,000. If you elect an amount that exceeds the guaranteed issue amount of $50,000, you will need to provide evidence of good health that is satisfactory to The Hartford before the excess can become effective.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0700	0.0700	0.0800	0.1100	0.1600	0.3000	0.5000	0.7300	1.1300	2.0400	4.0300	4.0300

To calculate your Monthly cost, please use the following formula(s):

_____ + $1,000 = _____ x _____ = $_____

Life Benefit Amount | Rate | My Monthly Cost

☐ I elect to purchase $_____ of Life coverage.

☐ I decline to purchase Life coverage.

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide all of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

Name:_____

	Full Name	Address	Social Security	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your spouse and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Disclaimer: Spousal consent does not apply to ERISA plans.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse:_____ Date:_____

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life Insurance coverage described in the Benefit Highlight Sheets and offered through JJF Management Services, Inc. dba Fitzgerald Auto Mall.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

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

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed_____ Date_____