ASSOCIATION OF THE UNITED STATES ARMY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
ONE HARTFORD PLAZA
HARTFORD, CONNECTICUT 06155
(A STOCK INSURANCE COMPANY)

MAIL YOUR COMPLETED APPLICATION TO:
AUSA GROUP INSURANCE PROGRAM
1200 E. GLEN AVE. PEORIA HEIGHTS, IL 61616-5348

QUESTIONS?
CALL 1.800.882.5707 OR
EMAIL CUSTOMERSERVICE@AUSACOVERAGE.COM

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN (AD&D) ENROLLMENT FORM

RETURN FORM TO ACTIVATE COVERAGE

ENCLOSE YOUR CHECK FOR YOUR FIRST PREMIUM PAYMENT (SHOWN BELOW), PAYABLE TO:
AUSA GROUP INSURANCE PROGRAM
1200 E. GLEN AVE. PEORIA HEIGHTS, IL 61616-5348

1. I WANT TO ENROLL IN THE AUSA ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN.

Fill in one circle and enclose a check for this amount.
For your convenience, after your initial payment, your monthly payment will be automatically deducted from your checking account.

BENEFIT AMOUNT	MEMBER ONLY	FAMILY
$250,000.00*	❍ $13.75	❍ $19.37
$200,000.00*	❍ $11.00	❍ $15.50
$150,000.00*	❍ $8.25	❍ $11.62
$100,000.00*	❍ $5.00	❍ $7.75
$50,000.00*	❍ $2.75	❍ $3.87

*At age 70, all coverage is reduced by 50% and will be further reduced by 50% at age 75. Family coverage is a percentage of your coverage.

2. PLEASE COMPLETE

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zipcode _____

Date of Birth (MM/DD/YY) _____ Phone Number _____

Sex: ❍ Male ❍ Female Email Address _____

3. PLEASE COMPLETE FAMILY INFORMATION (IF ENROLLING IN FAMILY COVERAGE)

Spouse Name (Last, First, Middle Initial) _____ Date of Birth (MM/DD/YY) _____ Sex: ❍ M ❍ F

Child Name: _____ Date of Birth (MM/DD/YY) _____ Sex: ❍ M ❍ F

Child Name: _____ Date of Birth (MM/DD/YY) _____ Sex: ❍ M ❍ F

Child Name: _____ Date of Birth (MM/DD/YY) _____ Sex: ❍ M ❍ F

4. PLEASE READ, THEN SIGN BELOW AND RETURN TO ENROLL.

I hereby enroll with Hartford Life and Accident Insurance Company of Hartford, CT, for coverage under the Accidental Death and Dismemberment Plan, ADD-13268. I have read and understand the conditions and exclusions of the program. I understand that my coverage will become effective upon the first day of the month following the administrator's receipt of this enrollment form and my first premium payment.

Member's Signature X _____ **Date** (MM/DD/YY) _____

COMPLETE THIS FORM. THEN MAIL IN FORM WITH YOUR FIRST PAYMENT.

Policy No. ADD-13268

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.
211698-AUSA-ADD-APP