

Participant Record/Contribution Change Form



Group Number:		Social Security Number:	
GENERAL INFORMATION (Please print or type)			
Plan Name:			
Employee Name: <input type="checkbox"/> Change		Last	First
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss			M.I.
Address: <input type="checkbox"/> Change			
City:		State:	Zip:
Date of Birth:	Date of Hire:	Date of Eligibility:	Date of Rehire: (if applicable)

Please refer to the Plan, the summary plan description or contact your Plan Administrator for information on the options available under the Plan.

DEFERRED PAYMENT

I elect to defer payment at this time. Severance from Employment Date: ____/____/____.

CONTRIBUTIONS

- A. **Elective Deferrals** - I elect to contribute _____% of my compensation each payroll period on a before-tax basis and _____ % on a Roth after-tax basis. (Must be a whole percentage)
- B. **Traditional After-Tax Contributions** - I elect to contribute _____ % of my compensation each payroll period on a traditional after-tax basis. (Must be a whole percentage)
- C. I wish to discontinue my contributions effective _____.

SALARY REDUCTION AGREEMENT

If elected above, by execution of the Participant Record/Contribution Change Form, I authorize my Employer to make contributions to the Plan by reducing my compensation as elected. This agreement shall continue in effect while I am employed by the Employer or until it is changed in accordance with the terms of the Plan. I understand that the terms of the Plan may provide the Employer with the authority to reduce or cease my 401(k) contributions to ensure the Plan satisfies the requirements of Section 401(k) of the Internal Revenue Code.

SIGNATURES

I acknowledge that I have read and understand the Full Disclosure Statement, as applicable to my state, located on page 2.

Employee Signature

Date

This Document has been received and accepted by the Plan Administrator.
(Required before submitting form to Hartford Life Insurance Company for processing.)

Plan Administrator Signature

Date

Please complete and return to your Plan Manager at:

Hartford Life Insurance Company
Retirement Plan Solutions
P.O. Box 1583
Hartford, CT 06144-1583

Full Disclosure Statement

Arkansas

“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.”

Colorado

“It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Services.”

District of Columbia

“WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.”

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.”

Indiana

“A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.”

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.”

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.”

New Hampshire

“Any person who, with a purpose to injure, defraud or deceive any insurance Company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20. However, the lack of such a statement shall not constitute a defense against prosecution under RSA 638:20.”

New Jersey

“Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.”

Ohio

“Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.”

Oklahoma

“WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.”

Pennsylvania

“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 subjects such person to criminal and civil penalties.”