Guaranteed Acceptance* Form for NEW Federal Employee Disability Income Insurance

Underwritten by
Hartford Life & Accident Insurance Company
Simsbury, Connecticut 06089

Administered by

IT'S EASY TO ENROLL. SEND NO MONEY NOW, you will be billed at a later date.
As a new Federal Employee within 45 days of your employment date, you cannot be denied this coverage.
No Health questions...No medical exam. But don't delay.

1. **Complete the sections below for your desired coverage with a specially-negotiated rate of $6.25 per month/per $10,000 of covered salary.**
2. Sign and date the Enrollment Form where indicated.
3. Return to: Wright USA, 706 Philadelphia Pike, Suite 1, Wilmington, DE 19809

Questions? Call us at 1-800-424-9801 www.WrightUSA.com

Member's Name (First, Middle Initial, Last)	☐ **Male** ☐ **Female**	**Home Phone Number**	
Home Street Address:	**City**	**State**	**Zip Code**
Ht: _____ **ft** _____ **inches Wt:** _____ **lbs**	**Date of Birth**	**Place of Birth (Town, State)**	
Day Time Phone Number	**Occupation:**		**Date of Hire:**
Government Agency Name:	**Retirement Option:** **CSRS:** ☐ **FERS:** ☐	**E-mail Address:**	

How did you hear about this plan?

COVERAGE INFORMATION: ☐ **Total Coverage Requested** **$**_____

Your Current Annual Salary $ _____ and Effective Date: _____/_____/_____

Prior Year Annual Salary (as of 12/31) $ _____ and Effective Date: _____/_____/_____

Your Insured Annual Salary amount may not exceed your Actual Annual Salary (including AUO/AVP if applicable).

Beneficiary Name/Relationship: _____

Beneficiary Phone number:_____ **Address:** _____

I hereby request coverage under the Federal Employee Disability Income Insurance plan. I represent that I am under age 60, work at least 17.5 hours a week and that the statements above are true and complete to the best of my knowledge and belief and are binding on any person. By selecting coverage under this plan, I recognize that the benefit amount cannot exceed 65% of my basic monthly pay (minus any Other Income Benefits). I understand that this program will not cover pre existing conditions (conditions for which I received medical advice or treatment within 12 months of this coverage) until 12 treatment free months have passed (ending on or after my effective date) or until the coverage has been in effect for 1 year.

X _____

Signature of Member **Date**

1-800-424-9801 • www.WrightUSA.com

*This policy is guaranteed acceptance, but it does contain a pre-existing condition limitation.

Policy Form # SRP-1311 A (HLA) (5389) & SRP-1311 A (HLA) (5391)
WGA11-1