GROUP VOLUNTARY LONG-TERM DISABILITY INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Just over 1 in 4 of today's 20 year-olds will become disabled before they retire (age 67).[1]

UPS Management Pilots as Members of the Aviation Health Association

A disability can happen to anyone. Long-term disability insurance helps protect your paycheck if you're unable to work for a long period of time after a serious condition, injury or sickness.

To learn more about Long-Term Disability insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION

BENEFIT PERCENTAGE (PERCENT OF YOUR EARNINGS)	MAXIMUM	MINIMUM (BASED ON MONTHLY INCOME LOSS BEFORE THE DEDUCTION OF OTHER INCOME BENEFITS)	BENEFIT STARTS (ELIMINATION PERIOD)	BENEFIT DURATION
30%	$6,000	The greater of $100 or 10% of the benefit	After 365 days disabled	Disabled before: Age 63 Benefit duration: As long as you are disabled Benefit duration maximum: The greater of your Social Security Normal Retirement Age or 3.5 years

PREMIUMS

See the Premium Worksheet.[2]

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.

AM I GUARANTEED COVERAGE?

If this is the first time you are eligible to elect coverage, evidence of insurability is not required.

If you did not elect coverage the first time it was offered to you, evidence of insurability is required to elect coverage.

This coverage is subject to a pre-existing condition exclusion, which is detailed on the Limitations & Exclusions sheet.[3]

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premium is provided on the Premium Worksheet.

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, or within 31 days of the date you have a change in family status.

WHEN DOES THIS INSURANCE BEGIN?

Insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect.

WHEN DOES THIS INSURANCE END?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you leave your employer, or the coverage is no longer offered.

WHAT DOES IT MEAN TO BE DISABLED?

Disability is defined in The Hartford's certificate with your employer.
Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are less than 80% of your pre-disability earnings

Pre-disability earnings are defined in your policy.

[1]U.S. Social Security Administration Fact Sheet. Web. 30 June 2017 https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf
[2]Rates and/or benefits may be changed.
[3]The Long Term Disability policy contains a Pre-Existing Condition Exclusion. Please refer to the certificate for more information on exclusions and limitations, such as Pre-Existing Conditions.

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This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation practices, please review our website http://thehartford.com/group-benefits-producer-compensation. Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LONG TERM DISABILITY INSURANCE

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS

- You must be under the regular care of a physician to receive benefits.
- You cannot receive disability insurance benefit payments for disabilities that are caused or contributed to by:
  - War or act of war (declared or not)
  - The commission of, or attempt to commit a felony
  - An intentionally self-inflicted injury
  - Your being engaged in an illegal occupation

PRE-EXISTING CONDITIONS

- Your insurance excludes the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your certificate, you will be covered for a disability due to that condition only if:
  - You have not received treatment for your condition for 3 months before the effective date of your insurance, or
  - You have been insured under this coverage for 12 months prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
  - You have already satisfied the pre-existing condition requirement of your previous insurer

LIMITATIONS

- **Mental Illness Limitation.** If you are disabled because of Mental Illness, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.
- **Substance Abuse Limitation.** If you are disabled because of alcoholism or use of narcotics, sedatives, stimulants, hallucinogens or other similar substance, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.

OFFSETS

- Your benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:
  - Social Security disability insurance (please see next section for exceptions)
  - Workers' compensation
  - Other employer-based insurance coverage you may have
  - Unemployment benefits
  - Settlements or judgments for income loss
  - Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Your benefit payments will not be reduced by certain kinds of other income, such as:
  - Retirement benefits if you were already receiving them before you became disabled
  - Retirement benefits that are funded by your after-tax contributions your personal savings, investments, IRAs or Keoghs profit-sharing
  - Most personal disability policies
  - Social Security cost-of-living increases

This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the Policy:

Insured's monthly [Pre-Disability Earnings/Basic Monthly Pay] $3,000
Long term disability benefits percentage x 60%
Unreduced maximum benefit $1,800
Less Social Security disability benefit per month - $900
Less state disability income benefit per month - $300
Total amount of long term disability benefit per month $600

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

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Premium Worksheet

Rates and/or benefits can change.

VOLUNTARY LONG TERM DISABILITY INSURANCE
Monthly Premium Amount (Cost per Pay Period – 12/Year)

To calculate your monthly premium amount, use the following formula.

_____	÷ 12 =	_____	÷ 100 =	_____	x	$1.0150	=	_____
Your Annual Earnings Maximum = $240,000		Your Monthly Earnings				Rate		Premium Amount

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ADDITIONAL SERVICES

UPS Management Pilots as Members of the Aviation Health Association

If you are enrolled in insurance coverage with The Hartford, you may also be eligible to receive additional services at no cost to you. These services help with challenges that come before and after a claim. Be sure to read the information provided below; The Hartford wants to be there when you need us.

SERVICES AVAILABLE

COVERAGE ENROLLED IN	ADDITIONAL SERVICES AVAILABLE
Disability	Ability Assist Counseling Services Health Champion Travel Assistance Services with ID Theft Protection and Assistance

ASKED & ANSWERED

WHAT IS ABILITY ASSIST COUNSELING SERVICES?

Ability Assist®[4] Counseling Services provides access to Master's- and PhD-degreed clinicians for 24/7 assistance if you're enrolled in our long term disability plan. This includes 3 face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

For more information on Ability Assist® Counseling Services:
Call 1-800-964-3577
Visit www.guidanceresources.com
Company name: **Abili** Company ID: **HLF902**

WHAT IS HEALTHCHAMPION?

HealthChampion[SM5] offers unlimited access to benefit specialists and nurses for administrative and clinical support to address medical care and health insurance claims concerns if you're enrolled in our long term disability plan. Service includes: guidance on health insurance claims and billing support, explanation of benefits, cost estimates and fee negotiation, information related to conditions and available treatments, and support to help prepare for medical visits.

For more information on HealthChampion[SM] Services
Call 1-800-964-3577
Visit www.guidanceresources.com
Company name: **Abili** Company ID: **HLF902**

WHAT IS TRAVEL ASSISTANCE SERVICES WITH ID THEFT PROTECTION AND ASSISTANCE?

Travel Assistance Services with ID Theft Protection and Assistance[3] includes pre-trip information to help you feel more secure while traveling. It can also help you access medical professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less when unexpected detours arise. The ID theft services are available to you and your family at home or when you travel.

For more information on Travel Assistance Services or ID Theft Services:
Call from United States: 1-800-243-6108
Call collect from other locations: 202-828-5885
Fax: 202-331-1528
Email: idtheft@europassistance-usa.com

Travel Assistance Identification Number: **GLD-09012**

You'll be asked to provide your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number, and your company policy number which can be obtained through your Human Resources/Personnel department.

If you have a serious medical emergency, please obtain emergency medical services first, and then contact Europ Assistance USA for follow-up.

[3] Travel Assistance and ID Theft Protection and Assistance are provided by Europ Assistance USA. Europ Assistance USA is not affliated with The Hartford and is not a provider of insurance services. Europ Assistance USA may modify or terminate all or any part of the service at any time without prior notice. None of the benefits provided to you by Europ Assistance USA as a part of the Travel Assistance and Identity Theft service are insurance. This brochure, the Travel Assistance and Identity Theft service Terms and Conditions of Use, and the Identity Theft Resolution Kit constitute your benefit materials and contain the terms, conditions, and limitations relating to your benefits. These services may not be used for business or commercial purposes or by any person other than the individual insured under The Hartford's group insurance policy.

[4] Ability Assist® is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.
[5] HealthChampion℠ is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.

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This Benefit Highlights Sheet is an overview of the non-insurance services being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the services as actually provided. Only the Service Provider can fully describe all of the provisions, terms, conditions, limitations and exclusions of your non-insurance service coverage.

Benefits Enrollment Form for UPS Management Pilots as Members of the Aviation Health Association
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
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Instructions: 1) Please print clearly with blue or black ink and provide complete information. (Missing information causes delays.) **2)** Please review the applicable benefit highlight/summary information for each product prior to electing coverage. You (employee) and your dependent(s) (if applicable) are only eligible for coverage as allowed by the applicable group policy. **3)** For each coverage, please check the appropriate box(es) to elect or decline coverage and enter amounts where necessary. **4)** Please sign and date the form. **5)** Submit the form as instructed by your benefits administrator by the enrollment deadline. (Do not submit or send the form directly to The Hartford.)

EMPLOYEE INFORMATION

Name (FIRST MI LAST)	**Employee ID**	**Date of Birth** (MM/DD/YYYY)

Date of Hire (MM/DD/YYYY)

Group Policy Number
805292

VOLUNTARY LONG TERM DISABILITY INSURANCE

Coverage for Employee Only	Benefit Amount	Monthly Premium Amount (Cost per Pay Period – 12/Year)	Elect Coverage or Continue Current	Decline Coverage
Employee	30% of earnings, up to $6,000 each month	$_____ (Requires EOI*)	☐	☐

Additional Information:
- Your benefit amount is based on your earnings; therefore, your benefit and premium amount will change as your earnings change.
- *If you were previously eligible for coverage and are enrolling for the first time, you must complete and submit an evidence of insurability (EOI) form/health application. The form is available from your employer.

CONFIRMATION & SIGNATURE

By signing below:
- I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.
- I understand and agree that: 1) If I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective; 2) My request for coverage may be denied by The Hartford; 3) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) Only the insurance policy(ies) issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy; 6) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 7) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.
- I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy, and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.
- I have read and understand the "Important Notice – Fraud Warning Statements" that applies to my state of residence.

Employee Signature	**Date of Signature**

END OF FORM – PLEASE REVIEW THE "IMPORTANT NOTICE – FRAUD WARNING STATEMENTS" ON THE FOLLOWING PAGE

Benefits Enrollment Form
Important Notice – Fraud Warning Statements
Hartford Life and Accident Insurance Company

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Please read the statement that applies to your state of residence prior to signing the enrollment form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

For residents of 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 a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or 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.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For residents of New Mexico and North Carolina: 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 submit to civil fines and criminal penalties.

For residents of New York (not applicable to Life Insurance): 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of 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.

For residents of Oregon: 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the 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 may have violated the state law.

FORM PA-9676 CREATION DATE: 3/16/2020

EMPLOYEE NAME:_____