

Please review the details of coverage under this NCOA-Endorsed Travel Accident Plan for members and their families. All coverage under this innovative plan increases automatically, but your rates do not.

NCOA-ENDORSED



## With 4-Way Accident Insurance, your coverage increases each year, through your 6th year of membership. Here's how:

<b>YOU CHOOSE COVERAGE UP TO:</b>		
\$100,000 accidental death	<b>AFTER 5 YEARS BENEFIT GROWS TO:</b>	\$150,000
\$350/day daily hospital		\$525/day
\$350/day daily recovery		\$525/day
\$350 /outpatient care visit		\$525/visit

### As an NCOA member in good-standing, your acceptance into this plan is guaranteed!

You cannot be turned down for this protection for any reason, as long as you are an NCOA member, at least 18 years of age, and a resident of the U.S. Your spouse who is at least 18 years of age, a resident of the U.S. and not legally separated or divorced from you is also eligible. You can also enroll your unmarried children under age 19 who are primarily dependent on you.

Have a question? Give us a call at **1-866-599-2656**. You can also contact us at [customerservice@driasi.com](mailto:customerservice@driasi.com).

To enroll, please complete the Acceptance Form below and return with first month's premium payment (or indicate and authorize the automatic payment method you prefer on the form). Mail to:

**The Hartford**  
P.O. Box 1197  
Minneapolis, MN 55440-9546

GBD-1000 B.3 (ADD-11249)  
36NCAD-0

## 4-Way Accident Insurance Acceptance Form for NCOA Members & Families

- You cannot be turned down.
- Choose protection for yourself and your family.

Member's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Daytime Phone Number (\_\_\_\_\_) \_\_\_\_\_

Email Address (optional) \_\_\_\_\_

Name of Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_  
(For Family Plan coverage, the Member is the beneficiary for spouse and children's coverage.)

#### I HAVE SELECTED:

##### Preferred Plan

- Individual (\$12.50)  
 Family (\$19.90)

- \$100,000 Accidental Death Benefit
- \$350/Day Hospital Daily Benefit
- \$350/Day Daily Recovery Benefit
- \$350 Outpatient Benefit

##### Standard Plan

- Individual (\$9.20)  
 Family (\$14.70)

- \$75,000 Accidental Death Benefit
- \$250/Day Hospital Daily Benefit
- \$250/Day Daily Recovery Benefit
- \$250 Outpatient Benefit

##### Basic Plan

- Individual (\$5.90)  
 Family (\$9.50)

- \$50,000 Accidental Death Benefit
- \$150/Day Hospital Daily Benefit
- \$150/Day Daily Recovery Benefit
- \$150 Outpatient Benefit

Rates and/or benefits may be changed on a class basis.

I have read and understand the conditions and exclusions of this insurance plan. I understand that my coverage will become effective upon receipt of my enrollment form and my first premium payment.

**X** \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Your Signature (Primary Insured) Date

#### Choose payment method:

- First month paid by Check or money order \$ \_\_\_\_\_ enclosed, payable to **The Hartford**, I understand I will be billed on a quarterly basis.
- Monthly through Automatic Bank Withdrawal. You must sign and date where indicated in the grey box to the right.
- Monthly through Credit Card  
 Visa  Mastercard  NCOA Mastercard  
Acct#: \_\_\_\_\_  
Exp: \_\_\_\_\_

#### Use This Form To Activate ABW Option

Sign, date and return with your Confirmation Form and a check for first month's payment. Your bank will make future payments automatically from this checking account.

**Save time. Save money. Save headaches.** You save time on addressing and mailing payment envelopes. You save money on postage. Best of all, you never have to worry about a gap in your protection because of a forgotten payment or overlooked bill.

#### Automatic Bank Withdrawal Request & Authorization

As a convenience to me, I authorize The Hartford Financial Services Group and/or its affiliated companies\* to withdraw funds from my account. I also authorize you, my financial institution, to pay from my account any checks, drafts or pre authorized electronic fund transfers from my account to the appropriate Company(ies) below.

**X** \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **X** \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Authorized Signature as Shown on the Account Joint Account or Other Authorized Signature



Hartford Life and Accident Insurance Company  
Simsbury, CT 06089

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