

BENEFIT PLANNING, INC.

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RE/MAX of California & Hawaii, Inc. Tax Deferred Retirement Savings Plan

Broker Owner Instructions/Checklist

Welcome to the RE/MAX of California & Hawaii, Inc. Tax Deferred Retirement Savings Plan! Some forms need to be filled out by you and returned to Benefit Planning, Inc. to begin.

Here's a checklist and brief explanation of what needs to be returned:

- Confidential Client Data Form: helps us to file the appropriate forms with the IRS and assure compliance
- Retirement Plan Census Form: this documents your compensation and that you have no employees
- Action By Written Consent and Adoption Agreement: establishment of plan to provide retirement benefits
- Participant Enrollment Form: this instructs Hartford how to invest your retirement plan assets
- Deferral Authorization Form: allows your Broker/Owner to begin making tax deferred contributions for you
- Beneficiary Designation/Spousal Consent Form
- Rollover Submission
- Enclose Your Check For The Annual Administration:

Safe Harbor	\$250.00
Non-Safe Harbor	\$500.00

Please complete all of the above forms and enclose your check in the return envelope provided.

RE/MAX of California & Hawaii, Inc. Tax Deferred Retirement Savings Plan

BROKER/OWNER CONFIDENTIAL CLIENT DATA FORM

1. LEGAL NAME OF COMPANY: _____
DBA: _____
2. COMPANY ADDRESS: _____

3. TELEPHONE: _____ 4. FAX : _____
5. EMAIL ADDRESS: _____
6. BROKER/OWNER: CONTACT: _____
ADDRESS: _____
(if different)
7. EMPLOYER ID: _____ 8. TRUST ID: _____
9. ACCOUNTANT: _____ 10. ATTORNEY: _____
FIRM: _____ FIRM: _____
ADDRESS: _____ ADDRESS: _____
_____ ZIP _____ _____ ZIP _____
PHONE: _____ PHONE: _____
FAX: _____ FAX: _____
cc: Yes No cc: Yes No
11. DATE BUSINESS BEGAN: _____ 12. PLAN YEAR END: _____
13. FISCAL YEAR END: _____
14. TYPE OF ORGANIZATION:
 SOLE PROPRIETOR LLP LLC C CORP. S CORP. NON-PROFIT PARTNERSHIP
15. PREDECESSOR BUSINESS (IF ANY) BEGAN: _____
 SOLE PROPRIETOR LLP LLC C CORP. S CORP. NON-PROFIT PARTNERSHIP
EMPLOYER ID(if different): _____

16. **OWNERSHIP:**

	OWNERSHIP	BD. OF DIRECTORS EXEC. COMMITTEE		COVERED BY ANY OTHER PLAN?	
		%	YES	NO	YES
NAME: _____ TITLE: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NAME: _____ TITLE: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NAME: _____ TITLE: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. **CONTROLLED ORGANIZATIONS & AFFILIATED SERVICE GROUPS:**

A. DOES THIS COMPANY OR ANY Owner OR THE SPOUSE OF ANY Owner LISTED ABOVE OWN ANY PART OF ANY OTHER ORGANIZATIONS? YES NO

B. If 17A is YES, complete a separate 'CONFIDENTIAL CLIENT DATA FORM'.

18. **CURRENT PLANS:**

ARE THERE, OR HAVE THERE EVER BEEN, ANY RETIREMENT PLANS NOW IN FORCE SPONSORED BY THIS COMPANY?

- | | |
|--|--|
| 1. <input type="checkbox"/> NONE | 7. <input type="checkbox"/> TARGET BENEFIT PENSION |
| 2. <input type="checkbox"/> PROFIT SHARING | 8. <input type="checkbox"/> TAX SHELTERED ANNUITY |
| 3. <input type="checkbox"/> 401(K) ONLY | 9. <input type="checkbox"/> EMPLOYEE STOCK OPTION |
| 4. <input type="checkbox"/> 401(K) PROFIT SHARING PLAN | 10. <input type="checkbox"/> SEP OR SARSEP |
| 5. <input type="checkbox"/> MONEY PURCHASE PENSION | 11. <input type="checkbox"/> SIMPLE IRA |
| 6. <input type="checkbox"/> DEFINED BENEFIT PENSION | 12. <input type="checkbox"/> SIMPLE 401K |

CERTIFIED BY: _____

DATE: _____

**ACTION BY WRITTEN CONSENT
AND ADOPTION AGREEMENT OF THE
RE/MAX OF CALIFORNIA & HAWAII, INC.
TAX DEFERRED RETIREMENT SAVINGS PLAN**

_____ (the "Employer"), a
 Corporation LLC Partnership Sole Proprietorship, hereby adopts the following resolutions:

WHEREAS, the Employer wishes to establish a plan to provide employee benefits;

WHEREAS, the undersigned have reviewed and decided to adopt, as a Participating Employer, the following Plan:

- RE/MAX of California & Hawaii, Inc. Tax Deferred Retirement Savings Plan fbo Broker-Owners (Safe Harbor), with an effective date of January 1, 2001
- RE/MAX of California & Hawaii, Inc. Tax Deferred Retirement Savings Plan fbo Broker-Owners, with an effective date of January 1, 2001

NOW, THEREFORE, BE IT RESOLVED, that the Employer adopts the Plan as of the date hereof as a PARTICIPATING EMPLOYER, effective as of the date shown above. For purposes of participants' salary reduction elections, the effective date will be the adoption date;

RESOLVED FURTHER, that the adoption of this Plan constitutes an amendment and restatement of the following existing plan of the Employer:

Notwithstanding any provisions of the Plan to the contrary, all Internal Revenue Code section 411(d)(6) protected benefits of the plan are hereby preserved with respect to benefits accrued as of the date hereof;

RESOLVED FURTHER, that, for purposes of the limitations on contributions and benefits under the Plan, prescribed by Section 415 of the Code, the "limitation year" shall be the Plan Year, as defined under the terms of the Plan;

RESOLVED FURTHER, that the officers or the agents of the Employer, are authorized and directed to execute such other instruments, and to perform such other acts, as may be necessary and proper to effectuate the intent and purposes of these resolutions.

DATE: _____

PARTICIPANT RECORD

Hartford Life Insurance Company

RE/MAX of CA & HI, Inc. Tax-Deferred Retirement Savings Plan FBO Broker/Owners

NON SAFE HARBOR PLAN

Group Number
GA # 17717

Social Security Number

Location Code _____
(Plan Sponsor Use Only)

GENERAL INFORMATION Please Print or Type

Employee Name: Mr. Ms. Last: _____ First: _____ M.I.: _____
Mrs. Miss.

Mailing Address: _____ / /

City: _____ State: _____ Zip: _____

Date of Birth: _____ Marital Status (M or S): _____ Date of Hire: _____ Date of Eligibility: _____

CONTRIBUTIONS

A. I wish to have % of my Before-Tax pay deducted each payroll period. \$ Annual Salary
(Must be a whole percentage, 1-15%)

B. I do not wish to contribute to the Plan at this time.

INVESTMENT ELECTION

I understand that the Plan Sponsor has directed my existing accumulated account balance (if any) under the Plan to be transferred to Hartford Life and invested in one or more of the funds below as specified by the Plan Sponsor. I elect to have my future contributions allocated based on my selections below (Must total 100% - Whole percentages only.) (For more information, contact your Plan Sponsor.)

- Alliance Technology Inv Opt -7A _____% _____% Mutual Qualified Inv Opt -7W
- Templeton Foreign Inv Opt -2X _____% _____% MFS Value Inv Opt -7V
- New Perspective Inv Opt -7X _____% _____% Brinson Tactical Allocation Inv Opt -7J
- MFS New Discovery Inv Opt -7T _____% _____% American Balanced Inv Opt -7D
- Franklin Balance Sheet Inv Opt -7L _____% _____% MFS Total Return Inv Opt -7U
- Hartford Capital Appreciation HLS Inv Opt -1J _____% _____% The Bond Fund of America Inv Opt -7E
- The Growth Fund of America Inv Opt -5Y _____% _____% Franklin Short-Intermediate US Government Inv Opt -7N
- AMCAP Inv Opt -7C _____% _____% Paine Webber Trust Company GIC Inv Opt -4M

SALARY REDUCTION AGREEMENT -401(k) Plans

By execution of this document, the Employee authorizes and the Employer agrees that any Before-Tax Contributions indicated above be made by reducing the Employee's salary. This agreement shall continue in effect only while employment with the Employer continues or until it is altered in accordance to your Plan provisions. The Employer reserves the right to make adjustments to the percentage of the Employee's Before-Tax Contributions in order to ensure the Plan's compliance with the Internal Revenue Code Section 401(k)/401(m).

SIGNATURES

I understand that these funds are issued under a Group Annuity Contract. All values provided by the contract, when based on investment experience of the above named accounts (except the Fixed Account), are variable and are not guaranteed as to a fixed dollar amount.

Employee Signature _____ Date: ____/____/____

This document has been received and accepted by the Plan Administrator.

Plan Administrator Signature _____ Date: ____/____/____

PARTICIPANT RECORD

Hartford Life Insurance Company

**RE/MAX of CA & HI, Inc. Tax-Deferred Retirement Savings Plan FBO Broker/Owners
SAFE HARBOR PLAN**

Group Number
GA # 17716

Social Security Number

(Plan Sponsor Use Only)

GENERAL INFORMATION Please Print or Type

Employee Name: Mr. Ms. Last: [] First: [] M.I.: []
Mrs. Miss.

Mailing Address: [] / [] / []

City: [] State: [] Zip: []

Date of Birth: [] Marital Status (M or S): [] Date of Hire: [] Date of Eligibility: []

CONTRIBUTIONS

A. I wish to have []% of my Before-Tax pay deducted each payroll period. \$ [] Annual Salary
(Must be a whole percentage, 1-15%.)

B. I do not wish to contribute to the Plan at this time.

INVESTMENT ELECTION

I understand that the Plan Sponsor has directed my existing accumulated account balance (if any) under the Plan to be transferred to Hartford Life and invested in one or more of the funds below as specified by the Plan Sponsor. I elect to have my future contributions allocated based on my selections below (Must total 100% - Whole percentages only.) (For more information, contact your Plan Sponsor.)

Table with 4 columns: Fund Name, Investment Option, Percentage, and another Percentage. Funds include Alliance Technology, Templeton Foreign, New Perspective, MFS New Discovery, Franklin Balance Sheet, Hartford Capital Appreciation, The Growth Fund of America, AMCAP, Mutual Qualified, MFS Value, Brinson Tactical Allocation, American Balanced, MFS Total Return, The Bond Fund of America, Franklin Short-Intermediate US Government, and Paine Webber Trust Company GIC.

SALARY REDUCTION AGREEMENT -401(k) Plans

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SIGNATURES

I understand that these funds are issued under a Group Annuity Contract. All values provided by the contract, when based on investment experience of the above named accounts (except the Fixed Account), are variable and are not guaranteed as to a fixed dollar amount.

Employee Signature: _____ Date: ____/____/____

This document has been received and accepted by the Plan Administrator.

Plan Administrator Signature: _____ Date: ____/____/____

DATE: _____

TO: Eligible employees of the

**RE/MAX of California & Hawaii, Inc.
Tax Deferred Retirement Savings Plan**

The above referenced plan has been established as a voluntary tax favored savings plan to enable you to save money on a before tax basis through payroll withholding.

All eligible employees must complete the Payroll Deduction Authorization Form, even if you are not interested in participating at this time.

INITIAL ENROLLMENT:

If this is your initial enrollment complete Section A and B of the Payroll Deduction Authorization Form. This form authorizes the company to withhold 401(k) contributions from your paycheck.

If you do not wish to participate, complete Section A and B, item #2.

CHANGE OF ELECTION:

If you have been participating and wish to change your election you must complete Section A and C of the Payroll Deduction Authorization Form.

If you wish to discontinue your pre-tax deferral contribution you must complete Section A and C, item #2.

Once your have completed the required steps please give the completed form(s) to your personnel department or representative.

RE/MAX of California & Hawaii, Inc.
Tax Deferred Retirement Savings Plan

PAYROLL DEDUCTION ELECTION FORM

A) **General Information:** Please complete this section whether or not you want to participate in payroll deduction contributions.

Name: _____

— (First) (Middle Initial) (Last)

Social Security Number: - -

Sex: M F Date of Birth: - -

B) **Initial Enrollment - Payroll Deduction Election**

1. I wish to make pre-tax payroll deferral contributions to the Plan and I hereby authorize my employer to deduct the following amount from each paycheck.

a. _____% of compensation, or

b. \$ _____ from each paycheck

2. I do not wish to contribute to the plan at this time.

C) **Change of Election - Payroll Deduction Election**

1. I wish to change my pre-tax payroll deferral contributions to the Plan and I hereby authorize my employer to deduct the following amount from each paycheck.

a. _____% of compensation, or

b. \$ _____ from each paycheck, or

2. I wish to discontinue pre-tax deferral contribution to the plan, and I hereby authorize my employer to stop deductions from my paycheck effective with the date of this election.

Date: _____

Signed By: _____

Beneficiary Designation / Spousal Consent Form

Hartford Life Insurance Company

RE/MAX of CA & HI, Inc. Tax Deferred Retirement Savings Plan FBO Brokers/Owners

Group Number

Social Security Number

EMPLOYEE INFORMATION

Employee Name	Last	First	M.I.
	<input type="text"/>	<input type="text"/>	<input type="text"/>

Are you currently married? Yes No

If you designate your spouse as the Primary Beneficiary for less than 100% of your death benefit, your spouse must sign the Spousal Consent Agreement below, unless this designation is not deemed applicable by your employer. You must also complete a QPSA waiver and Spousal Consent.

Receipt of this form in the offices of your Employer cancels all prior beneficiary designations and spousal consent filed with your Employer. No change of Beneficiary will take effect until this request has been received by your Employer.

BENEFICIARY INFORMATION

Upon the death of the Participant, all proceeds will be paid to the living beneficiaries in the order specified below. Only the Participant may change this designation. If no Beneficiary is designated, your death benefit will be paid to your spouse or, if unmarried, to the executors or administrators of your estate.

Please type or print the following information for each Beneficiary:

- | | |
|--------------------------------------|-------------------------------------|
| (1) Full Name of Individual or Trust | (5) Relationship to the Participant |
| (2) Address | (6) Percentage of Death Benefit |
| (3) Social Security Number | (7) Date of Trust (if applicable) |
| (4) Date of Birth | |

Primary Beneficiary(ies)
Contingent Beneficiary(ies)

Employee Signature

Date

SPOUSAL CONSENT AGREEMENT (If applicable)

To be completed if Primary Beneficiary is other than spouse; a QPSA waiver and Spousal Consent must also be completed.

This notice will certify that, as spouse of the Participant named above, I have consented to my spouse naming the person(s) listed above as Primary Beneficiary(ies) of any death benefits provided by the Plan. I hereby waive any and all rights I may have received under the Plan had this Spousal Consent not been granted.

Spousal Signature

Date

Signature of Witness (Plan Administrator or Notary Public)

Date

TO BE RETAINED BY PLAN ADMINISTRATOR

BENEFICIARY DESIGNATION

- A. If you are married, the beneficiary you designate must be your spouse unless your spouse consents in writing, as witnessed by a Notary Public, to designate another beneficiary.
- B. A married woman should be indicated by her own given name, not that of her husband. Example: Mary N. Jones, not Mrs. John R. Jones.
- C. Please complete the Beneficiary Designation **including** name, Social Security number, relationship, and percentage of death benefit (totaling 100%).

Listed below are some common beneficiary designations:

<u>Type of Beneficiary</u>	<u>Examples of Designations</u>
One Beneficiary	Jane Doe, wife, 100%
Two or more Primary Beneficiaries, equally among the survivors	John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% or equally among the survivor(s)
Two or more Primary Beneficiaries, with their share to their children	John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% <u>per stirpes</u>
Primary and Contingent Beneficiaries	Jane Doe, wife, 100% if living; otherwise, children
either	equally among the survivors
or	<u>per stirpes</u>
Participant's Estate	Participant's Estate
Trustee	Jane Doe, trustee under trust agreement * dated...

*If the word "trustee" is used in a beneficiary designation, the date of the execution of the agreement or a copy of the trust agreement must be furnished.

Rollover Submission

RE/MAX of CA & HI, Inc. Tax Deferred Retirement Savings Plan FBO Brokers/Owners

Group Number: _____

Social Security Number: _____

GENERAL INFORMATION (Please Print or Type)

Employee Name: Last <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	First	M.I.
Address:		
City:	State:	Zip:

ALLOCATION INFORMATION

(Selection must total 100%.)

I participated in a Retirement Plan qualified under section 401(a) of the Internal Revenue Code. I request that benefits accrued under that plan be credited to my account under the Group number above as rollover contributions and allocated among the investment options as indicated below.

Per current allocations

As listed Below

Alliance Technology Inv Opt -7A	____%	____%	Mutual Qualified Inv Opt -7W
Templeton Foreign Inv Opt -2X	____%	____%	MFS Value Inv Opt -7V
New Perspective Inv Opt -7X	____%	____%	Brinson Tactical Allocation Inv Opt -7J
MFS New Discovery Inv Opt -7T	____%	____%	American Balanced Inv Opt -7D
Franklin Balance Sheet Inv Opt -7L	____%	____%	MFS Total Return Inv Opt -7U
Hartford Capital Appreciation HLS Inv Opt -1J	____%	____%	The Bond Fund of America Inv Opt -7E
The Growth Fund of America Inv Opt -5Y	____%	____%	Franklin Short-Intermediate US Government Inv Opt -7N
AMCAP Inv Opt -7C	____%	____%	Paine Webber Trust Company GIC Inv Opt -4M

Make checks payable to:

Hartford Life Insurance Company

FBO _____
Name

SS# _____

GA# _____

P.O. Box 1583

Hartford, CT 06144-1583

I understand that all values provided by the contract, when based on investment experience of the above named investment options or mutual funds, whichever is applicable, are variable and are not guaranteed as to a fixed dollar amount.

Employee Signature

Date

ACCEPTANCE OF ROLLOVER

(Required before submitting form to Hartford Life for processing.)

The authorized signature below certifies eligibility and acceptance of the rollover of funds as instructed in this request. I have obtained any Beneficiary Designation and Spousal Waiver Consent forms that may be required by ERISA and the Internal Revenue Code, which designation applies to all of the participant's account.

Plan Administrator's Signature

Date

Rollover Instructions

How do I rollover my eligible distribution to my current employer's plan with Hartford Life?

Simply follow these directions:

Step One: Request the necessary documentation

Your *current* plan administrator will need to verify that the distribution is eligible for a rollover to the current plan under the Internal Revenue Code. See your plan administrator on what documentation is needed.

Contact your *prior* plan administrator and request the appropriate **withdrawal forms**.

Step Two: Complete the forms & get your current plan administrator's authorization

You must complete the following forms:

- (1) **Withdrawal form(s)**—Request from your *prior* plan administrator (see Step 1).
- (2) **Rollover Submission form**—Detach from your Hartford Life Enrollment Kit.
- (3) **Beneficiary Designation form**—Detach from your Hartford Life Enrollment Kit or request a copy from your *current* plan administrator. If you already enrolled in the plan, you do not need to complete this form.
- (4) **Participant Record form**—Detach from your Hartford Life Enrollment Kit or request a copy from your *current* plan administrator. If you are already enrolled in the plan, you do not need to complete this form.

Your *current* plan administrator must sign-off on the Rollover Submission form, and send the paperwork to Hartford Life.

IMPORTANT: Please request a copy of the signed Rollover Submission form from your *current* plan administrator. You will need to send this form along with your withdrawal form(s) to your prior provider.

If you are already enrolled in the plan, Hartford Life will invest your roll over contribution in accordance with your current elections. If you would like to change your allocation at any time, you may call Hartford Life's Voice Response Unit or log onto our Internet at <http://retire.hartfordlife.com>. If you are just rolling over an existing balance from another provider, but are not yet eligible to contribute, please select your allocation using the Rollover Submission form.

Step Three: Request the Benefit Check

Send your completed **withdrawal forms** to your *previous* plan administrator or institution where your eligible rollover amount is held **along with a copy of the signed Rollover Submission form**. Request that your *previous* plan administrator send the copy of the signed Rollover Submission form along with the check. In addition, please provide your *previous* plan administrator with the following information:

Checks should be made payable to:

Hartford Life Insurance Company FBO (Your Name, Social Security Number, and Plan Number)

Checks should be mailed to: Hartford Life Insurance Company Retirement Plan Solutions P.O. Box 1583 Hartford, CT 06144-1583	For overnight mail, please use the following address: Hartford Life Insurance Company Retirement Plan Solutions 200 Hopmeadow Street Simsbury, CT 06089
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Please contact Hartford Life for wire instructions or other electronic transmissions.

If you have any questions during the rollover process, please contact the Hartford Life Service Specialists at 1-800-874-2502, and select option #2, available Monday through Friday 8:00 a.m. to 8:00 p.m. Eastern Time.

The retirement program is through a group annuity contract issued by Hartford Life Insurance Company, Simsbury, CT 06089 (Countrywide HL-14991; NY & FL HL-14973).

Following is The Hartford's Privacy Policy and Practices describing the company's policy on disclosure of its customers' personal information. We are sharing this information with you as it pertains to the privacy of personal information provided to Hartford Life Insurance Company in its capacity as a retirement program provider and issuer of group IRA contracts.

**Privacy Policy and Practices of
The Hartford Financial Services Group, Inc.
and its Affiliates (The Hartford)**

Applicable to The Hartford's United States Customers

We at The Hartford value our customers' trust and are committed to the responsible management, use and protection of personal information. All insurance companies must collect a certain amount of personal information to service customers and administer business. This notice describes our policy regarding the collection and disclosure of personal information.

- 1) Personal information, as used in this notice, means information that identifies an individual personally and is not otherwise available to the public. It includes personal financial information such as credit history, income, financial benefits, policy or claim information. It also includes personal health information such as individual medical records or information about an illness, disability or injury.
- 2) We collect personal information to support our normal business operations. We may obtain personal information directly from the customer, from customer-related transactions and from third parties, such as a consumer reporting agency. Personal information such as name, address, income, payment history or credit history are gathered from sources such as applications, transactions and consumer reports.
- 3) The Hartford's employees have access to personal information in the course of doing their jobs, which includes underwriting policies, paying claims, developing new products or advising customers of our products and services.
- 4) We may share personal financial information with our affiliates, such as insurance companies, banks, agents, brokerage firms and administrators.
- 5) To service our customers and administer our business, we may also share information with unaffiliated third parties, including agents, brokerage firms, insurance companies, administrators and service providers and as otherwise permitted or required by law. In addition, we may share personal financial information with other unaffiliated third parties who are assisting us by performing services or functions, such as conducting surveys, marketing our products or services, or offering financial products or services under a joint agreement between us and one or more financial institutions.

Prior to sharing personal financial information with unaffiliated third parties, except as described in this policy, we will give affected customers an opportunity to direct that such information not be disclosed.

(continued)

6) We may disclose personal health information with proper written authorization or as otherwise permitted or required by law.

7) We use manual and electronic security procedures to maintain the confidentiality and integrity of personal information in our possession and guard against its unauthorized access. Some techniques we employ to protect information include locked files, user authentication, encryption, firewall technology and the use of detection software.

We are responsible for identifying information that must be protected, providing an adequate level of protection for that data and granting access to protected data only to individuals who must use it in the performance of their job-related duties. Employees who violate our Privacy Policy will be subject to disciplinary action, which may include termination.

8) We will continue to follow this policy regarding personal information even when a customer relationship no longer exists.

The Hartford will notify customers of our Privacy Policy at the inception of our business relationship and annually thereafter. The Privacy Policy is subject to change at any time. We will notify customers of any modifications at least annually.