



**THE
HARTFORD**



Official Member No. _____
 Name: _____
 Address _____
 City _____ State ____ Zip _____
 Email Address _____

To Apply, Please Complete and Submit by Following 3 Easy Steps:

1. Fill out the information in the editable application below.
2. Save the electronic version of your completed application to your desktop.
3. [Click Here](#) to electronically upload and submit your completed application.

**DISABILITY INCOME INSURANCE APPLICATION
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

Hartford, Connecticut 06155

1

Policyholder: (and Participating Organization)
NASW ASSURANCE SERVICES, INC.

Policy No.:
AGP-5883; AGP-5884

Certificate No.: (Leave Blank)

2

Member Name (First, Middle Initial, Last) _____
 Street _____
 City, State, Zip Code _____
 Daytime Phone No. (____)____-____ Email Address _____
 Date of Birth Male Female Height: ft. in. Weight: lb.
 Age Last Birthday Place of Birth (State/Country) _____
 Occupation _____
 Business Address: Street _____
 City, State, Zip Code _____
 Business Telephone Number (____)____-____ Annual Salary \$ _____
 Beneficiary - Print full name & relationship to you
 Name _____ Relationship _____

3

Spouse/Domestic

Partner's Name (First, Middle Initial, Last), if applying

Street

City, State, Zip Code

Daytime Phone No. () -

Date of Birth Male Female Height ft. in. Weight lb.

Age Last Birthday Place of Birth (State/Country)

Spouse/Domestic Partner's Occupation

Business Address: Street

City, State, Zip Code

Business Telephone Number () - Annual Salary \$

Beneficiary - Print full name & relationship to you
Name Relationship

4

COVERAGE REQUESTED:

Member Coverage

- Basic Plan (\$100 - \$1,200)
- Extended Plan (\$100 - \$1,200)
- Select Plan (\$100 - \$6,000)

Monthly Benefit Amount: \$

Spouse/Domestic Partner Coverage

- Basic Plan (\$100 - \$1,200)
- Extended Plan (\$100 - \$1,200)
- Select Plan (\$100 - \$6,000)

Monthly Benefit Amount: \$

5

Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company? Yes No If Yes, give details:

Name	Company	Monthly Benefit	Benefit Period	Waiting Period	To be replaced? <input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No

Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 30 hours per week) 90 days before the date of this application? Yes No Spouse/Domestic Partner YES NO YES NO

Is the Monthly Benefit Amount herein applied for 75% of your Basic Monthly Pay minus any Other Income Benefits? Yes No Spouse/Domestic Partner YES NO YES NO

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PLEASE COMPLETE THE FOLLOWING:

All questions are answered to the best of my knowledge and belief:

- | | Member | | Spouse | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| | YES | NO | YES | NO |
| 1. In the past 10 years, has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for: | | | | |
| A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system or sleep disorder? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| C. Colitis, ulcer, kidney disease or disorder or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands or thyroid? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, muscles, or joints, including neck or back disorders? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. During the past 5 years, has anyone proposed for coverage consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this application; or been confined or treated in any hospital, sanatorium or similar institution? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Is anyone proposed for coverage now pregnant? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| If yes, Name: _____ | | | | |
| When is the baby due? _____ | | | | |
| What was your pre-pregnancy weight? _____ | | | | |
| Are there any medical complications? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

If you answered "Yes" to any of the above medical questions, please explain the details below.

Question Number and Condition	Name of Family Member	Dates	For any question answered "yes" please provide details, your physician's name, full address, and phone number (Required for processing)

AUTHORIZATION

I hereby certify that I have read or have had read to me all statements and answers in this application, and in any other application or medical form required by Hartford Life and Accident Insurance Company, and that they are full, complete, and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk. I understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs. Subject to the deferred effective date provision, I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; or employer; to give Hartford Life and Accident Insurance Company or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage.

Hartford Life and Accident Insurance Company will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the policy. This information will be treated as confidential.

I authorize Hartford Life and Accident Insurance Company to give information about me to: its reinsurer(s), any other insurance company to whom I may apply for Life or Health Insurance, or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my coverage or, if no coverage has been issued one (1) year from the date of this application. I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request.

I certify that I have received the Notice of Insurance Information Practices. I agree that this document and all of its contents shall form a part of my enrollment request for group benefits.

PRE-EXISTING CONDITIONS LIMITATION: I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12-month period prior to my effective date of coverage will not be covered until one (1) year after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation.

I further understand that any condition excluded or limited by the policy or by a Health Waiver attached to my certificate will not be covered under this policy at any time.

Notice: I understand that California law prohibits an HIV test from being required or used by Health Insurance Companies as a condition of obtaining health insurance coverage.

Member's Signature (Sign name in full)

 

Required

Date

Required

Spouse/Domestic Partner's Signature (if applying)

 

Required

Date

Required

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 may be guilty of a crime and may be subject to fines and confinement in prison.

PA-9357 (HLA)(CA)(2-12)

C1424

60038

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101399 (Basic) 101400 (Select) 101401 (Extended)
Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

Questions? Call toll-free 1-866-591-8267
SEND NO MONEY NOW!

(For Administrative Use Only)

SIGNATURE SUBMITTED ONLINE

Confirmation Number: _____ Date/Time Submitted Online: _____ / _____
M M D D Y Y Y Y

Return your completed application today to:

NASW Assurance Services
Group Insurance Program Administrators
P.O. Box 26450, Phoenix, AZ 85068

To submit the application online:

1. Ensure all the information in the application has been completed.
2. Save the electronic version of your completed application to your desktop.
3. Click Here to electronically upload and submit your completed application.

NOTE: Please print out an application for your records.