THE HARTFORD

NASW™ Assurance Services
Where Social Workers Come First™

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

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Policyholder: (and Participating Organization)	Policy No.:	Certificate No.: (Leave Blank)
NASW ASSURANCE SERVICES, INC.	**AGP-5728**	

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Member Name (First, Middle Initial, Last)

Street

City, State, Zip Code

Daytime Phone No. ( ) - Email Address

Date of Birth MM-DD-YYYY ◯ 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:

PA-9357 (HLA)(CA)(2-12) 48836

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

Street

City, State, Zip Code

Daytime Phone No. ( ) -

Date of Birth MM DD YYYY ◯ 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:

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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: $

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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?
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

	You		Spouse/ Domestic Partner	
Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 30 hours per week)	YES	NO	YES	NO
90 days before the date of this application?	◯	◯	◯	◯
Is the Monthly Benefit Amount herein applied for 70% of your Basic Monthly Pay minus any Other Income Benefits?	◯	◯	◯	◯

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PLEASE COMPLETE THE FOLLOWING:
All questions are answered to the best of my knowledge and belief:

	Member		Spouse	
1. In the past 10 years, has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for:	YES	NO	YES	NO
A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?	◯	◯	◯	◯
B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system or sleep disorder?	◯	◯	◯	◯
C. Colitis, ulcer, kidney disease or disorder or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system?	◯	◯	◯	◯
D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	◯	◯	◯	◯
E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands or thyroid?	◯	◯	◯	◯
F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, muscles, or joints, including neck or back disorders?	◯	◯	◯	◯
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	◯	◯	◯	◯
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?	◯	◯	◯	◯
3. Is anyone proposed for coverage now pregnant?	◯	◯	◯	◯
If yes, Name: _____				
When is the baby due? _____				
What was your pre-pregnancy weight? _____				
Are there any medical complications?	◯	◯	◯	◯

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)

For residents of the State of California and New York, the maximum benefit amount is 75% of your regular gross monthly rate of pay based on your latest statement of wages earned and taxes withheld (Form W-2).

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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 I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or 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.

SIGN HERE

Member's Signature (Sign name in full)

X _____ Required

Date MM-DD-YYYY Required

SIGN HERE

Spouse/Domestic Partner's Signature (if applying)

X _____ Required

Date MM-DD-YYYY 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) B7634 48836

100285 (Basic) 101195 (Select) 100345 (Extended)
Disability Form Series includes GBD-1000, GBD-1200, or state equivalent. (AGP-5728)

Questions? Call toll-free 1-866-514-8974
SEND NO MONEY NOW!

87 76798 00

(For Administrative Use Only)

☐ **SIGNATURE SUBMITTED ONLINE**

Confirmation Number: _____ Date/Time Submitted Online: ____ – ____ – _____ / _____
MM DD YYYY

To submit the application on-line:

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.