THE HARTFORD

NASW™ Assurance Services
Where Social Workers Come First™

Official Member No.:_____

Name:_____

Address:_____

City/State/Zip:_____

GROUP TERM LIFE INSURANCE APPLICATION
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Hartford, Connecticut 06155 Policy # AGL-1828

1

Member Name (First, Middle Initial, Last):

Street:

City, State, Zip Code:

Phone Number: ( ) - Email Address:

Date of Birth (MM/DD/YYYY): - - ◯ Male ◯ Female Height: ft. in. Weight: lb.

Place of Birth (State/Country):

Beneficiary - Print full name & relationship to you

Name: Relationship:

The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

2

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

Date of Birth (MM/DD/YYYY): - - ◯ Male ◯ Female Height: ft. in. Weight: lb.

Place of Birth (State/Country):

3

Amount Desired ($1,000 minimum up to $500,000 maximum in $1,000 increments) Please indicate if request is for:

◯ Proposed Insured:$, ◯ Spouse/Domestic Partner: $,

Once the insured attains the age of 71, all benefits reduce by 20% each year until the insured attains age 74. From ages 74-99 benefits payable are 20% of the original benefit amount purchased.

4 Please Complete the Following:

	Member	Spouse/ Domestic Partner
In the last 2 years, have you or your Spouse/Domestic Partner been unable to perform the full-time duties of your occupation for 10 consecutive days? If not employed, have you or your Spouse/Domestic Partner been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90-day period immediately preceding the date of this application for 10 consecutive days?	◯Yes ◯No	◯Yes ◯No
All questions are answered to the best of my knowledge and belief:		
1. In the past 10 years, has anyone proposed for coverage ever 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?	◯Yes ◯No	◯Yes ◯No
B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system or sleep disorder?	◯Yes ◯No	◯Yes ◯No
C. Colitis, ulcer, kidney disease or disorder, or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive systems?	◯Yes ◯No	◯Yes ◯No
D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	◯Yes ◯No	◯Yes ◯No
E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands or thyroid?	Yes ◯No	◯Yes ◯No
F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?	◯Yes ◯No	◯Yes ◯No
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	◯Yes ◯No	◯Yes ◯No
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 has anyone proposed for coverage been confined or treated in any hospital, sanatorium or similar institution?	◯Yes ◯No	◯Yes ◯No

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, including dates, your physician's name, full address, phone number and fax number. (Required for Processing)

(Attach sheet of paper if additional space is needed.)

5 Please Read Carefully All Items and Sign Below:

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

I hereby certify that I have read all statements and answers in this application, and in any other application or medical form required by The Hartford, 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 paid my first premium.

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

The Hartford will use the above information to decide if and to what extent I or my dependents are eligible for insurance coverage or benefits under the policy. This information will be treated as confidential.

I authorize The Hartford to give information about me to any other insurance company to whom I or my dependent may apply for Life and 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 or authorized 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 my dependent's 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.

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)

X

Date (MM-DD-YYYY): ☐☐-☐☐-☐☐☐☐ Required

SIGN HERE

Spouse/Domestic Partner's signature (If applying)

X

Date (MM-DD-YYYY): ☐☐-☐☐-☐☐☐☐ Required

SIGN HERE

Please check "Yes" or "No" on the next line.
By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? You ◯Yes ◯No Spouse/Domestic Partner ◯Yes ◯No

PA-9356 (HLA) (CA)

Life Form Series Includes GBD-1000, GBD-1100, or state equivalent.

B7637 100364 100366

Return completed form today to:
NASW Assurance Services Group Insurance Program Administrators,
P.O. Box 26450, Phoenix, AZ 85068-9955
Questions? Call toll-free 1-866-514-8974