Official Member No.:____________________________

Name:____________________________

Address:____________________________

City/State/Zip:____________________________

GROUP TERM LIFE INSURANCE APPLICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Hartford, Connecticut 06155

Policyholder: (and Participating Organization)	Policy No.:	Certificate No.: (Leave Blank)
NATIONAL ASSOCIATION OF SOCIAL WORKERS	AGL-1950	

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: lbs.

Place of Birth (State/Country):

Beneficiary - Print full name & relationship to you

Name: Relationship:

2

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

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

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 75, all benefits reduce by 20%. At ages 78, 81, and 84 benefits reduce another 20%. Please refer to your Certificate of Insurance for further details.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.
Policies sold in New York are underwritten by Hartford Life Insurance Company.

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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, or if not employed, 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 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?	○ 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?	○ 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?	○ 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 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.

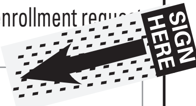
Question Number and Condition	Name of Family Member	Dates	For any question answered "yes" please provide details, including dates, your physician's name, full address, phone number and fax number. (Required for Processing)

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

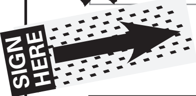
5 Please read carefully all items and sign below:

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

I/We hereby certify that I/we have read 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/our knowledge and belief. I/We understand that any material misrepresentations in this application could cause a claim to be denied under any insurance issued based on this application. I/We also agree that a copy of this application shall be attached to and form a part of any certificate issued. I/We also understand that the Company may request whatever additional evidence of insurability it needs.
Subject to the deferred effective date provision, I/we understand that coverage will not become effective until the Company grants its underwriting approval. I/We do not receive temporary or conditional insurance coverage just because I/we submit an application and paid my/our first premium.
I/We 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/our physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status except drug and alcohol treatment information.
Hartford Life and Accident Insurance Company will use the above information to decide if and to what extent I/we are eligible for insurance coverage or benefits under the Policy. This information will be treated as confidential. I/We authorize Hartford Life and Accident Insurance Company to give information about me/us to any other insurance company to whom I/we 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/We understand that upon written request I/we 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/our coverage or, if no coverage has been issued one (1) year from the date of this application.
I/We understand that a photocopy of this form is as valid as the original, and that I/we have a right to receive a copy of this form upon request.
I/We certify that I/we have received the Notice of Insurance Information Practices. I/We agree that this document and all of its contents shall form a part of my/our enrollment request for group benefits.



X ______________________ X ______________________



Member's signature (Sign name in full) **Spouse/Domestic Partner's signature** (If applying)

Date (MM-DD-YYYY): __ __ - __ __ - __ __ __ __ **Date (MM-DD-YYYY):** __ __ - __ __ - __ __ __ __

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

READ YOUR CERTIFICATE CAREFULLY. CERTAIN WAR RISKS ARE NOT ASSUMED.

Form PA-9356 (HLA) (NY) Life Form Series Includes GBD-1000, GBD-1100, or state equivalent.

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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