THE HARTFORD

APPLICATION FOR DISABILITY INCOME INSURANCE
Hartford Life And Accident Insurance Company

Hartford, Connecticut 06155

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.

Policyholder: **NASW Assurance Services, Inc.**
Policy No.: **AGP-5883; AGP-5884**
Certificate No.:

1

Policyholder: (and Participating Organization)	Policy No.:	Certificate No.: (Leave Blank)
NASW ASSURANCE SERVICES, INC.	**AGP-5883; AGP-5884**	

2 Please Complete

MEMBER NAME (First, Middle Initial, Last)

Street

City, State, Zip Code

Phone Number ( ) -

Date of Birth MM DD YYYY Gender: ◯ Male ◯ Female Height ft. in. Weight lbs.

Age Last Birthday Place of Birth (City/State/Country)

Occupation

Business Address

City, State, Zip Code

Business Phone Number ( ) - Monthly Earning/Basic Monthly Pay

Beneficiary - Print full name & relationship to you

Name Relationship

SPOUSE/DOMESTIC PARTNER NAME (First, Middle Initial, Last)

Street

City, State, Zip Code

Phone Number ( ) -

Date of Birth MM DD YYYY Gender: ◯ Male ◯ Female Height ft. in. Weight lbs.

Age Last Birthday Place of Birth (City/State/Country)

Occupation

Business Address

City, State, Zip Code

Continued →

2 Please Complete continued

Business Phone Number ( ) - Monthly Earning/Basic Monthly Pay

Beneficiary - Print full name & relationship to you

Name Relationship

3 Please Complete the Following

	You YES	You NO	Spouse/Domestic Partner YES	Spouse/Domestic Partner 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) immediately before the date of this application?	◯	◯	◯	◯
Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company? If yes, give details.	◯	◯	◯	◯

Name	Company	Monthly Benefit	Benefit Period	Waiting Period	To be replaced?
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

	You YES	You NO	Spouse/Domestic Partner YES	Spouse/Domestic Partner NO
Is the Monthly Benefit Amount herein applied for equal to or less than 75% of your Basic Monthly Pay minus any Other Income Benefits?	◯	◯	◯	◯

4 Please Select Your Desired Coverage

MEMBER

◯ Basic Plan ($100 – $1,200)
◯ Extended Plan ($100 – $1,200)
◯ Select Plan ($100 – $6,000)

Monthly Benefit Amount*

SPOUSE/DOMESTIC PARTNER

◯ Basic Plan ($100 – $1,200)
◯ Extended Plan ($100 – $1,200)
◯ Select Plan ($100 – $6,000)

Monthly Benefit Amount*

*Benefits are available in $50 increments with a minimum benefit of $100.

5 Please Complete the Following continued

PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS BELOW:

	Member YES	Member NO	Spouse/Domestic Partner YES	Spouse/Domestic Partner 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?	◯	◯	◯	◯
B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?	◯	◯	◯	◯
C. Colitis, ulcer, liver, kidney disease, 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?	◯	◯	◯	◯
F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?	◯	◯	◯	◯
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder?	◯	◯	◯	◯
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? MM DD YYYY				
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	For any question answered "yes" please provide your physician's name, full address and phone number (Required for Processing)

Continued →

6 Please Read Carefully All Items and Sign Below

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 the 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; consumer reporting agency; Medical Information Bureau; 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 or employment status.

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 understand the Medical Information Bureau, Inc. will release records of information only to the Hartford Life and Accident Insurance Company.

I authorize the Hartford Life and Accident Insurance Company to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., 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 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.

SIGN HERE X _____ **Date** M M D D Y Y Y Y

Member (Type Your Name)

SIGN HERE X _____ **Date** M M D D Y Y Y Y

Spouse (Type Spouse Name - if applying)

STATE NOTICE: Any person who includes any false or misleading information on an application or filing a claim for an insurance policy is subject to criminal and civil penalties. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, penalties may include imprisonment, fines, denial of insurance, and civil damages.

Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If while in the state of Florida, a person knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, the person is guilty of a felony in the third degree. Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false, misleading or deceptive information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to substantial civil and/or criminal penalty where and to the extent allowed by state law.

Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

Questions? Call toll-free 1-866-591-8267

SEND NO MONEY NOW!

87 76798 00

(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.