



SECTION 1		
Policyholder (and Participating Organization): National Association of Social Workers	Policy No.: AGL-1950	Certificate No.: (Leave Blank)

SECTION 2			
Member's Name (First, Middle Initial, Last)	<input type="checkbox"/> Male	Height: _____ ft. _____ in.	Weight: _____ Lbs. (if currently pregnant, pre-pregnancy weight)
Street:			
City:	State:	Zip Code:	
Date of Birth:	Place of Birth (State/Country):	Preferred Phone #:	
Social Security Number:	Email Address:		
NASW Member Number:	Member's Occupation:		
<input type="checkbox"/> I am a current NASW Member			

SECTION 3			
Spouse/Domestic Partner's Name (First, Middle initial, Last) if applying	<input type="checkbox"/> Male	Height: _____ ft. _____ in.	Weight: _____ Lbs. (if currently pregnant, pre-pregnancy weight)
Street:			
City:	State:	Zip Code:	
Date of Birth:	Place of Birth: (State/Country)	Preferred Phone #:	
Spouse/Domestic Partner's Occupation		Social Security Number:	

SECTION 4		
LIFE INSURANCE		
Amount Desired (\$1,000 minimum up to \$100,000 maximum in \$1,000 increments):		
Member: \$ _____	Spouse/Domestic Partner: \$ _____	
The Spouse/Domestic Partner may not be covered under a Plan with benefits greater than 100 percent of the Member's Plan.		
Age Reduction Rule: 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.		
	MEMBER	SPOUSE/DOMESTIC PARTNER
By applying for this insurance, do you intend to replace, discontinue, or change an existing life insurance policy that is not otherwise expiring?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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SECTION 5

PLEASE COMPLETE THE FOLLOWING:	MEMBER	SPOUSE/ DOMESTIC PARTNER				
<p>1. In the past 5 years have you been diagnosed or treated for high blood pressure, cancer, tumor, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any disease or disorder of the glands, thyroid, any lung or respiratory disorder, liver, kidney or genitourinary disease or disorder, including hepatitis, alcohol or drug abuse or dependency, epilepsy, mental or nervous disorder, neurological impairment, bone, joint, back, muscle or connective tissue disorder, or Chronic Fatigue Syndrome? If "yes", indicate:</p> <table border="1" data-bbox="120 411 1031 573"> <tr> <td data-bbox="120 411 698 489">Diagnosis by your physician:</td> <td data-bbox="703 411 1031 489">Date of diagnosis:</td> </tr> <tr> <td colspan="2" data-bbox="120 495 1031 573">Treatment including medication, dosage, date last taken:</td> </tr> </table> <p>Has the medical professional treating you for this condition released you from care?</p>	Diagnosis by your physician:	Date of diagnosis:	Treatment including medication, dosage, date last taken:		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis by your physician:	Date of diagnosis:					
Treatment including medication, dosage, date last taken:						
<p>2. Have you ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC*) or any other Disorder of the Immune System as defined below?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<p>3. In the past 12 months have you been confined in a hospital, nursing home, sanatorium or similar institution (excluding maternity)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				

AIDS Related Complex (ARC)* is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

SECTION 6

Please read all items carefully and sign below.

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

Notice

To the best of your knowledge, you are required to notify Hartford Life and Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date coverage is approved.

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

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We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, and copies of medical records which you have authorized us to review, and information obtained from MIB, Inc.

Authorization

I, an undersigned applicant, authorize Hartford Life and Accident Insurance Company, together with its affiliates, ("Company") to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

In the event that I cannot be reached via telephone, I authorize a representative of the Company to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that he or she is calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company by telephone.

Yes, you may leave a message as indicated above. No, please do not leave a message.

(If not checked, you will not be contacted by phone.)

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize any employer, any health or benefits plan, physician, counselor, medical professional, hospital, clinic or medical facility, laboratory, MIB, Inc., pharmacy or pharmacy benefits manager, motor vehicle violation reporting agency, consumer reporting agency that possesses my protected Personal Health Information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), drug and alcohol use history, other insurance coverage or employment status to furnish such protected health information to the Company or its representative. The Company may only use information disclosed under this Authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

I acknowledge that I am currently a member of the Association and understand I must retain membership to be eligible for this insurance plan.

I hereby acknowledge that I have read 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 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 any deferred effective date provision, I understand that coverage will not become effective until (a) the Company grants its underwriting approval; and b) at the time of payment of the first premium, I am living, and my insurability remains the same as that described in the application. I do not receive temporary or conditional insurance coverage just because I submit an application and paid my first premium.

I authorize the Hartford Life and Accident Insurance Company to give information about me or my dependents to any other insurance company to whom I or my dependents may apply for Life and Health Insurance, the MIB, Inc., 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.

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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 this application 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.

Member's signature (Sign name in full)	_____	Date: _____	_____
	Required		Required
Spouse/Domestic Partner's signature (if applying)	_____	Date: _____	_____
	Required		Required

SECTION 7

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.

For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For residents of Arkansas: 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 is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Colorado: 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. 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of District of Columbia: 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 is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For the residents of Louisiana: 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 is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Pennsylvania: 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 information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

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