

# GROUP DISABILITY INCOME INSURANCE APPLICATION



**HARTFORD LIFE INSURANCE COMPANY**  
Simsbury, Connecticut 06089

**Section 1**

Policyholder: American College of Emergency Physicians	Policy No.: AGP-5683	Certificate No.: (Leave Blank)
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**Section 2**

Name: (First, Middle Initial, Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: __ft. __in. Weight: ___lb.
Street :	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):		Age Last Birthday:	Place of Birth (State/Country):
Daytime Phone No.: ( )	Business Telephone: ( )	Email Address: _____	
Occupation:		Pre-Disability Earnings: \$ _____	
Business Address: Street:			
City:		State:	Zip Code:

**Section 3**

<p><b>COVERAGE REQUESTED:</b></p> <p>Member Coverage:</p> <p><input type="checkbox"/> New Coverage: Monthly Benefit Amount: \$ _____</p> <p>Payment Period – to age 65</p> <p>Waiting Period: <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days</p> <p>Payment Period – 5 years</p> <p>Waiting Period: <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days <input type="checkbox"/> 365 days</p> <p><input type="checkbox"/> Change in Coverage: Increase my Monthly Benefit Amount to: \$ _____</p> <p>Payment Period – to age 65</p> <p>Change in Waiting Period: <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days</p> <p>Payment Period – 5 years</p> <p>Change in Waiting Period: <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days <input type="checkbox"/> 365 days</p>
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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company.



**Section 6**

If you answered "Yes" to any of the above medical questions, please explain the details below.

Question Number and Condition	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.)

**Section 8**

**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 understand that any material misrepresentations in this application could cause a claim to be denied under any insurance issued based on this application. 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.

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; Medical Information Bureau, Inc.; 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 except drug and alcohol treatment information.

Hartford Life and Accident Insurance Company will use the information to decide if and to what extent we are 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 or information only to Hartford Life and Accident Insurance Company.

I authorize 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 agree that this document and all 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/our effective date of coverage will not be covered until I have gone 12 months ending on or after my/our effective date of coverage without medical advice or treatment for that condition, or until 1 year after my/our 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/our 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/our certificate will not be covered under this Policy at any time.

**SECTION 9**

I wish to pay my premiums:  Quarterly  Semi-annually  Annually

**SECTION 10**

Member's signature (Sign name in full) \_\_\_\_\_  
Required

Date \_\_\_\_\_  
Required

**FRAUD WARNING STATEMENT**

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 thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.



**Administrator:**  
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Sioux Falls, SD 57103  
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