



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

**Section 1**

Policyholder: American College of Emergency Physicians	Policy No.: AGL-1752	Certificate No.: (Leave Blank)
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**Section 2**

Proposed Insured Name: (First, Middle Initial, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY):
Street :	Height: ____ ft. ____ in.	
City: State: Zip Code:	Weight: ____ lb.	
Preferred Phone No.: ( )	Proposed Insured's Occupation:	
Beneficiary-Print full name & relationship to you		
Name: _____ Relationship: _____		
The Proposed Insured will be the beneficiary for any Dependent Coverage desired.		

**Section 3**

Spouse's Name: (First, Middle Initial, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY):	Height: ____ ft. ____ in. Weight: ____ lb.
Place of Birth (State/Country):			

**Section 4**

Please indicate if request is for:

New Coverage  
Proposed Insured \$ \_\_\_\_\_  
Spouse \$ \_\_\_\_\_

Change in Coverage  
Proposed Insured's Current benefit amount: \$ \_\_\_\_\_ Additional benefit requested: \$ \_\_\_\_\_ Total benefit: \$ \_\_\_\_\_  
Spouse's Current benefit amount: \$ \_\_\_\_\_ Additional benefit requested: \$ \_\_\_\_\_ Total benefit: \$ \_\_\_\_\_

If Dependent Coverage is desired, complete the following:

Dependent Full Name	Relationship	Birth Date

**Section 5**

PLEASE COMPLETE THE FOLLOWING:		YES	NO
At any time during the past 12 months to the present, have you or your Spouse smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff?			
In the last 2 years have you or your Spouse 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?			
All questions are answered to the best of my knowledge and belief:		YES	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, kidney disease or disorder, or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive systems?		
	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, excluding HIV?		

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		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?		

**Section 6**

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.)

**Section 7**

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 first premium.

I/We 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/our or my/our dependent's 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 understand the Medical Information Bureau, Inc. will release records or information only to Hartford Life and Accident Insurance Company.

I/We authorize Hartford Life and Accident Insurance Company to give information about me/us or my/our dependents to any other insurance company to whom I/we or my/our dependents may apply for Life and Health Insurance, the Medical Information Bureau, 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 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 my/our dependent's 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.

**Section 8**

Proposed Insured's signature (Sign name in full) \_\_\_\_\_ Date \_\_\_\_\_  
Required Required

Spouse's signature (if applying) \_\_\_\_\_ Date \_\_\_\_\_  
Required Required

**Section 9**

**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:  Yes  No