

**GROUP LIFE INSURANCE APPLICATION**



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

**Section 1**

Policyholder: American College of Emergency Physicians	Policy No.: AGL-1905	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.      Weight: ____lb.	
City:                      State:                      Zip Code:	Proposed Insured's Occupation:	
Preferred Phone Number: (    )	Proposed Insured's Occupation:	
Beneficiary-Print full name & relationship to you		
Name: _____ Relationship: _____		

**Section 3**

Please select:					
Proposed Insured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000

**Section 4**

PLEASE COMPLETE THE FOLLOWING:	YES	NO
At any time during the past 12 months to the present, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff?		

**Section 5**

All questions are answered to the best of my knowledge and belief:		YES	NO
1	During the last year , have you been diagnosed or been treated for a heart condition, diabetes, kidney or liver disorder, lung or respiratory disease, neurological impairment, blood or circulatory disorder (including high blood pressure but excluding HIV), alcohol or drug abuse, cancer, or enlarged lymph glands?		
2	Have you ever been diagnosed or been treated for Acquired Immune Deficiency Syndrome(AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV?		
3	Have you been confined in a hospital, nursing home, sanatorium or similar institution in the last 2 months (excluding maternity)?		

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**

Please read carefully all items and sign below.

**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION**

I hereby certify that I 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 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 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 paid my 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 or my 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 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 or my dependents to any other insurance company to whom I or my 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 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 my dependent's 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 of its contents shall form a part of my enrollment request for group benefits.

**Section 7**

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

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