GROUP DISABILITY INCOME INSURANCE APPLICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut 06155

Section 1

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

Section 2

Name: (First, Middle Initial, Last)		☐ Male ☐ 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

COVERAGE REQUESTED:

Member Coverage:

☐ New Coverage: Monthly Benefit Amount ($500-$10,000 in $500 increments) : $_____

Payment Period – to age 65

Waiting Period: ☐ 90 days ☐ 180 days ☐ 365 days

Payment Period – 5 years

Waiting Period: ☐ 30 days ☐ 90 days ☐ 365 days

☐ Change in Coverage: Increase my Monthly Benefit Amount to: $_____

Payment Period – to age 65

Change in Waiting Period: ☐ 90 days ☐ 180 days ☐ 365 days

Payment Period – 5 years

Change in Waiting Period: ☐ 30 days ☐ 90 days ☐365 days

Section 4

Do you have any Disability Income Insurance in force or pending in this or any other company? ☐Yes ☐No If yes, give details:

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

Have you been actively engaged in the full-time duties of your occupation (at least 30 hours per week) immediately before the date of this application? ☐ Yes ☐No

Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Pre-Disability Earnings minus any Other Income Benefits? ☐Yes ☐No

Section 5

	PLEASE COMPLETE THE FOLLOWING:	YES	NO
All questions are answered to the best of my knowledge and belief:			
1	In the past 10 years, have you 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 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, excluding HIV tests?	☐	☐
2	During the past 5 years, have you 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	Are you now pregnant? When is the baby due? What was your pre-pregnancy weight? Are there any medical complications?	☐	☐

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. Sign and date additional piece of paper.)

Section 7

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 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 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), 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 authorize Hartford Life and Accident Insurance Company, or its reinsurers, to make a brief report of my personal health information to Medical Information Bureau.

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 effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until 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.

SECTION 8

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

SECTION 9

Member's signature (Sign name in full) _____ Date_____

Required 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.

Hagan Barron Intermediaries

Administrator:
PO Box 1889
Sioux Falls SD, 57101
Telephone Number: (877-285-4445)