



# GROUP TERM LIFE INSURANCE APPLICATION

Hartford Life and Accident Insurance Company  
Simsbury, Connecticut 06089

Policyholder's Name	<b>American College of Emergency Physicians</b>	Policy No.	<b>AGL-1752</b>	Certificate No.	<b>LEAVE BLANK</b>
Proposed Insured Name	(First, Middle Initial, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	MM/DD/YYYY	
Preferred Phone No.	--- - --- - ----	Place of Birth	(State/Country)	Height: ___ft. ___in.	Weight: ___lb.
Mailing Address				Email	
City, State, Zip					

## BENEFICIARY - Print full name & relationship to you

Name (First, Middle Initial, Last) Relationship

The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

Spouse's Name	(First, Middle Initial, Last) if applying	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	MM/DD/YYYY
Place of Birth	(State/Country)	Height: ___ft. ___in.	Weight: ___lb.	

Amount Desired (\$25,000 minimum up to \$500,000 maximum (\$250,000 maximum for Spouse) in \$25,000 increments)

Please indicate if request is for:

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

Change in Coverage  
Member's current benefit amount: \$ \_\_\_\_\_ Additional benefit request: \$ \_\_\_\_\_ Total benefit: \$ \_\_\_\_\_  
Spouse's current benefit amount: \$ \_\_\_\_\_ Additional benefit request: \$ \_\_\_\_\_ Total benefit: \$ \_\_\_\_\_

Child Coverage  Yes  NO

IF REQUEST IS TO CHANGE EXISTING COVERAGE PRINT ONLY ADDITIONAL AMOUNT DESIRED

If Dependent Coverage is desired, complete the following:

Dependent Full Name	Relationship	Birth Date

PLEASE COMPLETE THE FOLLOWING:		Member		Spouse	
		Y	N	Y	N
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? If not employed, have you or your Spouse 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:					
1.	In the past 10 years, has anyone proposed for coverage ever 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 or sleep disorder?				
	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 or thyroid?				
	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 has anyone proposed for coverage consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this application; or has anyone proposed for coverage been confined or treated in any hospital, sanatorium or similar institution?				

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, your physician's name, full address and phone number (Required for processing)

(Attach sheet of paper if additional space is needed.)

*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 The Hartford, 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 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.

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 The Hartford 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 except drug and alcohol treatment information.

The Hartford will use the above information to decide if and to what extent I or my dependents 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 The Hartford.

I authorize The Hartford to give information about me to any other insurance company to whom I or my dependent 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.

**Notice:** I understand that California law prohibits an HIV test from being required or used by Health Insurance Companies as a condition of obtaining health insurance coverage.

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

Date MM / DD / YYYY  
 \_\_\_\_\_  
 Required

Spouse's Signature (if applying)  
 \_\_\_\_\_  
 Required

Date MM / DD / YYYY  
 \_\_\_\_\_  
 Required

<p><b>Please check "Yes" or "No" on the next line.</b>          By applying for this insurance, do you intend to replace, discontinue, or change an exiting policy of life insurance?</p> <p>YOU: Yes <input type="checkbox"/> No <input type="checkbox"/>      SPOUSE: Yes <input type="checkbox"/> No <input type="checkbox"/></p>
--

The Hartford® is 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.