GROUP TERM LIFE INSURANCE APPLICATION

Hartford Life and Accident Insurance Company
Simsbury, Connecticut 06089

Policyholder **American College of Emergency Physicians** Policy No. **AGL-1752** Certificate No. LEAVE BLANK

Proposed Insured Name (First, Middle Initial, Last) ☐Male ☐Female DOB M M / D D / Y Y Y Y

Mailing Address Height: __ft. __in. Weight: ___lb.

City, State, Zip

Preferred Phone No. ___-___-____ Proposed Insured's Occupation

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) ☐Male ☐Female Height: __ft. __in. Weight: ___lb.

Place of Birth (State/Country) DOB M M / D D / Y Y Y Y

Please indicate if request is for:

☐ New Coverage

Proposed Insured: $ ____________ Spouse: $ ____________

☐ Change in Coverage

Proposed Insured's current benefit amount: $ _______ Additional benefit request: $ _______ Total benefit: $ _______

Spouse's current benefit amount: $ _______ Additional benefit request: $ _______ Total benefit: $ _______

If Dependent Coverage is desired, complete the following:

Dependent Full Name	Relationship	Birth Date

PLEASE COMPLETE THE FOLLOWING:	Member Y	Member N	Spouse Y	Spouse 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, 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:	Member Y	Member N	Spouse Y	Spouse N
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?				
C. Colitis, ulcer, kidney 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?				
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?				

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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 detail's, including dates, 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/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/our 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 or my/our dependents 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 to any other insurance company to whom I/we or my/our dependents may apply for Life and 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 or authorized 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/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.

Proposed Insured's Signature (Sign name in full) ______________________ Date MM/DD/YYYY

Required   Required

Spouse's Signature (if applying) ______________________ Date MM/DD/YYYY

Required   Required

Please check "Yes" or "No" on the next line.
By applying for this insurance, do you intend to replace, discontinue, or change an exiting policy of life insurance?

YOU: Yes ☐ No ☐   SPOUSE: Yes ☐ No ☐

Administered by:
Hagan Barron Intermediaries
P.O. Box 1889
Sioux Falls, SD 57101

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plan. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, “Not Related” as their stated relationship. If you need assistance, contact the company’s representative or your own legal advisor.

A beneficiary designation may be changed at any time upon written request.

Please note that a Power of Attorney (POA) may not have the authority to change a beneficiary.

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Does	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, “See attached”, on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Insured/Member) and dated.**

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Clear Form

BENEFICIARY DESIGNATION

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group and direct that the insurance proceeds payable under the policy be paid as indicated below.

Insured/Member Name:	Date of Birth:	Social Security Number:
Insured/Member Address:		Telephone Number: ( )
Policyholder:		Policy Number:

NAMING YOUR LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact the company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, according to the terms under the policy.

PRIMARY BENEFICIARY(IES)

Name: ________ Date of Birth: ________
Address: ________ Telephone Number: ( )
Social Security Number: ________ Relationship: ________ Benefit Percent: ____ %

Name: ________ Date of Birth: ________
Address: ________ Telephone Number: ( )
Social Security Number: ________ Relationship: ________ Benefit Percent: ____ %

Name: ________ Date of Birth: ________
Address: ________ Telephone Number: ( )
Social Security Number: ________ Relationship: ________ Benefit Percent: ____ %

CONTINGENT BENEFICIARY(IES)

Name: ________ Date of Birth: ________
Address: ________ Telephone Number: ( )
Social Security Number: ________ Relationship: ________ Benefit Percent: ____ %

Name: ________ Date of Birth: ________
Address: ________ Telephone Number: ( )
Social Security Number: ________ Relationship: ________ Benefit Percent: ____ %

Disclaimer: Spousal consent does not apply to ERISA plans

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Insured named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of the group life term and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Insured/Member's Spouse: ________ **Date:** ________

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Insured/Member: ________ **Date:** ________

Please note that a Power of Attorney (POA) may not have the authority to change a beneficiary.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK

IMPORTANT REPLACEMENT NOTICE

THIS NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY INSURANCE REGULATION NO. 60

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into a paid-up or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to contemplating a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you to decide whether the replacement is in your best interest.

I HAVE READ THE IMPORTANT REPLACEMENT NOTICE THAT ACCOMPANIED THIS APPLICATION.

Do you intend to replace, in whole or in part, any existing life insurance or annuity?
Yes_____No______

Date: __________________Signature of Applicant: ___________________________________

Date: __________________Signature of Applicant: ___________________________________

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