Union Plus Life Insurance Plan

Group Term Life Insurance Application

THE HARTFORD

Hartford Life and Accident Insurance Company,
Hartford, CT 06155
Policyholder: AFL-CIO Mutual Benefit Fund
Policy No. AGL-1660

UNIONPLUS

1. PLEASE COMPLETE ALL INFORMATION

PROPOSED INSURED MEMBER

Name _____ Address _____

City _____ State _____ Zip _____

International Union Name _____ Local Union # _____ Place of Birth _____
City State Country

Date of Birth _____ / _____ / _____ ☐ Male ☐ Female Preferred Phone Number (_____) _____ – _____
Month Day Year

Height _____ Weight _____ Email (optional) _____
ft in lbs

SPOUSE (if applying)

Name _____

Date of Birth _____ / _____ / _____ ☐ Male ☐ Female Place of Birth _____
Month Day Year City State Country

Height _____ Weight _____
ft in lbs

2. DESIRED AMOUNT OF COVERAGE

MEMBER: _____ SPOUSE (IF APPLYING): _____

3. INDICATE BENEFICIARY AND ANSWER QUESTION:

Member's Beneficiary(ies) (Print Full Name and relationship to you):

Name(s): _____ Relationship(s): _____

Spouse's Beneficiary(ies) (Print Full Name and relationship):

Name(s): _____ Relationship(s): _____

	MEMBER		SPOUSE (if applying)	
	YES	NO	YES	NO
Any time during the past 12 months to the present, has anyone proposed for coverage smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff?	☐	☐	☐	☐

4. PLEASE COMPLETE THE FOLLOWING:

	MEMBER		SPOUSE (if applying)	
	YES	NO	YES	NO
1. 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?	☐	☐	☐	☐
2. 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 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?	☐	☐	☐	☐
3. 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 have you 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 on the next page.

Mail to Union Plus Insurance Program, P.O. Box 47060, Phoenix, AZ 85068-7060

Application for Group Term Life Insurance (continued)

If you answered "Yes" to any of the above medical questions, please explain the details below.		
Question Number and Condition	**Name of Family Member**	**For any question answered "yes" please provide 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 Company, 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 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.

Hartford Life and Accident Insurance Company 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 Life and Accident Insurance Company.

I authorize the 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 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.

✘_____ ✘____/____/____ ✘_____ ✘____/____/____

Member's Signature (Sign name in full) Date Spouse's Signature Date

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?

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

STATE NOTICE

Any person who includes any false or misleading information on an application or filing a claim for an insurance policy is subject to criminal and civil penalties. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, Penalties may include imprisonment, fines, denial of insurance, and civil damages.

Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If while in the state of Florida, a person knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, the person is guilty of a felony in the third degree.

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, misleading or deceptive 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 be subject to substantial civil and/or criminal penalty where and to the extent allowed by state law.