THE HARTFORD

UNIONPLUS

International Union No.: _____

Local Union No.: _____

Name: _____

Address: _____

City/State/Zip: _____

# GROUP TERM LIFE INSURANCE APPLICATION
# HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Hartford, Connecticut 06155

Policy # AGL-1660

## SECTION 1

| Policyholder: (and Participating Organization) | Policy No.: | Certificate No.: (Leave Blank) |
|---|---|---|
| UNION PLUS INSURANCE PROGRAM | 1660 | |

## SECTION 2

Proposed Insured's Name: (First, Middle Initial, Last)

◯ Male ◯ Female Date of Birth (MM/DD/YYYY): - -

Street

City, State, Zip Code: Height: ft. in. Weight: lb.

Preferred Phone No. ( ) - Proposed Insured's Occupation:

Beneficiary – Print Full Name & relationship to you

Name Relationship:

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

## SECTION 3

Spouse's Name (First, Middle Initial, Last), if applying

Date of Birth (MM/DD/YYYY): - - Height: ft. in. Weight: lb. ◯ Male ◯ Female

Place of Birth (State/Country):

## SECTION 4

Please Select:

| | | | | |
|---|---|---|---|---|
| Proposed Insured: | ◯ $25,000 | ◯ $50,000 | ◯ $75,000 | ◯ $100,000 |
| Spouse: | ◯ $25,000 | ◯ $50,000 | ◯ $75,000 | ◯ $100,000 |

## SECTION 5

PLEASE COMPLETE THE FOLLOWING:

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? ..... ◯ Yes ◯ No

FORM PA-9356 (HLA) (NY)

44604



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## SECTION 6

All questions are answered to the best of my knowledge and belief:

1 During the last year , have you or your Spouse 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? ..... ○ Yes ○ No

2 Have you or your Spouse 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? ..... ○ Yes ○ No

3 Have you or your Spouse been confined in a hospital, nursing home, sanatorium or similar institution in the last 2 months (excluding maternity)? ..... ○ Yes ○ No

## SECTION 7

**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

## SECTION 8

Please review your answers to these questions to be sure that you have answered them fully and truthfully. Answering "Yes" to any of these questions may disqualify you from acceptance for coverage at this time.

I/We understand that coverage will not become effective until the Company grants its underwriting approval and the administrator is in receipt of the first payment of premium. I/We do not receive temporary or conditional insurance coverage just because I/we submit an application. By signing this application, I/we acknowledge that the application is true and accurate for each person to be insured.

By signing below, I/we acknowledge that I/we have read and agree to all terms on the bottom of this form.

## SECTION 9

**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 submitted 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/We authorize Hartford Life and Accident Insurance Company, or its reinsurers, to make a brief report of my/our 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.

## SECTION 10

**Proposed's Insured's signature** (Sign name in full) X _____ Required **Date:** __ __ - __ __ - __ __ __ __ Required

**Spouse's signature** (if applying) X _____ Required **Date:** __ __ - __ __ - __ __ __ __ Required

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**READ YOUR CERTIFICATE CAREFULLY. CERTAIN WAR RISKS ARE NOT ASSUMED.**

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**Return completed form today to:**

Union Plus Insurance Programs, P.O. Box 47060, Phoenix, AZ 85068-9963

**Questions?** Call toll-free 1-800-393-0864



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