THE HARTFORD

International Union No.: _____

Local Union No.: _____

Name: _____

Address: _____

City/State/Zip: _____

TO APPLY:

1. **Complete and sign the application**
2. **Send no money with your application. You will be billed upon approval.**
3. **Use the postage paid envelope provided to return to:**

UNIONPLUS

Union Plus Insurance Program
PO Box 40760
Phoenix, AZ 85068-9963

GROUP TERM LIFE INSURANCE APPLICATION
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Hartford, Connecticut 06155

Policy # AGL-1660

SECTION 1

Policyholder's Name	Policy No.:
UNION PLUS INSURANCE PROGRAM	1660

SECTION 2

Member Name (First, Middle Initial, Last)

◯ Male ◯ Female Date of Birth: - - Height: ft. in. Weight: lb.

Place of Birth (State/Country):

Street

City, State, Zip Code: Phone No. ( ) -

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

◯ Male ◯ Female Date of Birth: - - Height: ft. in. Weight: lb.

Place of Birth (State/Country):

SECTION 4

Please Select:

Member: ◯ $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) (CA)

44605

SECTION 6

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

1 During the last 5 years, 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 tests? ..... ○ Yes ○ No

3 Have you or your spouse been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity)? ..... ○ Yes ○ No

SECTION 7

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 below.

SECTION 8

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 submitted 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.

SECTION 9

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

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

SECTION 10

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

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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