Instructions for Completing Policyholder Related Information within the Life and Disability Personal Health Applications for California Residents

Purpose

This document explains how to complete the policyholder-related sections of the Personal Health Application(s) for California residents. It outlines which information you (as the policyholder) must provide so that your employee's application is processed in an accurate and timely manner.

Instructions

In addition to this aid, please be sure to read all instructions on Page 1 of the application and the Policyholder's Responsibility section on Page 2.

What you need to complete

The sections are as follows:

Page	Areas of Attention
3	Complete the Policyholder Information section found at the top of the page.
4	Complete the Who Requires an Application section found at the top of the page.
5	Complete the Coverage Summary section in its entirety. This section begins in the middle of the page Note: Basic Life Coverage amounts are important and must be included for all Applicants requesting additional Life coverage.

Once you have completed these sections, please forward the entire form and the applicant job aid to your employee.

Contact Information

We are here when you need us. If you have any questions about your application, please contact us at **(800) 523-2233** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.



Re: Your personal health application

Dear Applicant,

Thank you for choosing benefits coverage with The Hartford¹. Enclosed you will find your personal health application.

Completing the personal health application

As you complete the application, please understand that the enrollment elections you made through your employer at the time you enrolled are final and are in no way changed by completing this personal health application. In addition, any beneficiary information on file with your employer will not be updated as a result of any information provided on the enclosed personal health application.

Simply complete the shaded areas on the application, referring to the attached instructions, and submit all pages to the address indicated on the first page of the application. Please note that the questions that are not shaded are not relevant to your benefits coverage and any answers provided to those questions will be disregarded.

What you can expect from us

Once you submit your personal health application, we will process it as quickly as possible. We will promptly notify you and your employer of the status of your application, and will let you know if any additional information is needed. If your applications are approved, your premium will be paid through a payroll deduction administered by your employer. Any premium and payment information provided on the personal health application will not change your payroll deduction.

Supporting you through the process

At The Hartford, we are here when you need us. If you have any questions about your application, please contact us at **(800) 331-7234** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, or email us at medical.uw@hartfordlife.com.

Sincerely,

Medical Underwriting
The Hartford Group Benefits
1-800-331-7234
Medical.uw@hartfordlife.com

¹ The Hartford[®] is The 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. Home Office of both companies is Simsbury, CT.

Completing your Life Personal Health Application - for California Residents (Applicant)

Purpose

This document explains how to complete your Personal Health Application. It outlines which information you must provide so that your application is processed in an accurate and timely manner.

Instructions

In addition to this aid, please be sure to read all shaded instructions in the shaded areas of the application, including instructions on Page 1 of the application, and the Applicant's Responsibility section on Page 2.

After completing the application, please submit the application to the address listed on the first page. Please keep a copy of the completed application for your records.

What you need to complete

All shaded areas of the application need to be completed to ensure your application is processed in an accurate and timely manner. The shaded sections are as follows:

Page	Areas of Attention
3	Complete the Proposed Insured Information section.
4	Complete the section, Applicants Requiring Health Evaluation , found in the middle of the page.
	Note: You only need to complete the first table that lists the names of applicants, their relationship to you, their date of birth, height, weight and gender.
9-10	Complete the shaded health questions in the Health Information section. For each question on Page 9, please indicate a <i>yes</i> or <i>no</i> answer in the box provided to the right of the question. Provide any details for <i>yes</i> answers on Page 10. Use a separate piece of paper if needed.
11	 Read the Notice at the top of the page. Complete questions 15-20 by providing a yes or no answer in the box provided to the right of the question. Read the Certification section. If you understand and agree with the terms of these sections, please sign and date the bottom of the page in the space provided. Note: If you are applying for Spouse coverage only, then only the Spouse needs to
	sign the form.
12	 Read the Authorization and Fraud Notice sections. If you understand and agree with the terms of these sections, please sign and date the bottom of the page in the space provided.
	Note: If you are applying for Spouse coverage only, then only the Spouse needs to sign the form.
13	 Read the Applicant Authorization section. Print your name and date of birth at the top of page where the space is provided. If you understand and agree with the terms of these sections, please sign and date the bottom of the page in the space provided.

Contact Information

We are here when you need us. If you have any questions about your application, please contact us at **(800) 331-7234** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, or email us at medical.uw@hartfordlife.com.

INTRODUCTORY MATERIAL



PERSONAL HEALTH APPLICATION

Applicants must complete this form if they have requested insurance coverage for themselves or any of their family members and are required to show evidence of good health.

For questions about how to complete this form, call Hartford Life at

1-800-331-7234

Upon Completion:

Send both the Policyholder and Applicant sections of this form to:
Hartford Life and Accident Insurance Company
Group Medical Underwriting
P.O. Box 2999
Hartford, CT 06104-2999

Please remember your form can not be processed without your signature and current date.

Please keep a copy of the completed forms for your records.



[] Personal Health Application for Insurance	[]
Hartford Life and Accident Insurance Company	Policy Number []
Hartford, Connecticut		



[

Life Personal Health Application Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Form PA-9199 (Rev. 3/07)

INSTRUCTIONS

Instructions

Policyholder's Responsibility

- 1. Fill out the Policyholder Section completely. Please note an incomplete form will result in a delay in processing your request for insurance. Refer to your Policy and employee records. These records are your property and are not on file with Hartford Life and Accident Insurance Company's Group Medical Underwriting Department.
- 2. In Section #1 "Who Requires an Application" indicate with a check mark all who are required to provide evidence of good health employee, spouse or child and for each, check the reason(s) why. Consult your Policy for all requirements, limitations and exceptions. Employees or spouses signing up beyond their new hire eligibility period will be responsible for costs associated with the underwriting process.
- 3. In Section #2 "Coverage Summary," complete all coverage amounts for each Applicant. Basic Life Coverage amounts are important and must be included for all Applicants requesting additional Life coverage. Consult your employee records to determine current coverage amounts. Please note that Hartford Life and Accident Insurance Company does not have access to employee records for amounts of coverage already in force.
- 4. After completing the Policyholder section, forward the entire form, including both the Policyholder and Applicant Sections, to the employee to complete for all Applicants that need evidence of insurability.
- 5. No premiums should be deducted on additional amounts until a final decision regarding coverage is received from Hartford Life and Accident Insurance Company's Group Medical Underwriting Department.

Applicant's Responsibility

- 1. Make sure your Employer has already completed the Policyholder Section of this form in full.
- 2. The Policyholder Section clarifies which Applicants need to show evidence of good health and should be listed on this Application. Refer to "Who Requires an Application" in the **Policyholder Section** of the form where a box has been marked for each person who is required to fill out an Application you (the employee), your spouse or child. Enter the names of these individuals on the Application under "Applicants Requiring Health Evaluation," and fill in the information requested.
- 3. Answer all questions completely and accurately. Even minor details like height and weight are very important and must be accurate.
- 4. An Applicant who has not enrolled by the new hire eligibility period (shown in the Policyholder Section #1) will be responsible to pay for the cost of physical exams, medical records or medical tests if they are required during the underwriting process.
- 5. YOU, THE EMPLOYEE MUST SIGN THIS FORM (even if you yourself are not applying for coverage). Use your full legal signature, and enter the date signed. Your spouse must sign this form ONLY if using this form to apply for coverage. He or she must use a full legal signature, and enter the date signed.
- 6. BOTH THE EMPLOYER AND EMPLOYEE SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY WITHIN 30 DAYS OF THE SIGNATURE DATE.
- 7. The medical and personal information you complete on this form will be considered "current" for 90 days. Leaving information blank can result in delays or may result in your file being closed.

Coverages underwritten by Hartford Life and Accident Insurance Company

The Hartford is Hartford Financial Services Group, Inc. and its subsidiaries, including the issuing companies of Hartford Life Insurance Company and Hartford Life and Accident Insurance Company.

POLICYHOLDER INFORMATION

Policyholder Section Personal Health Application Please print in blue or black ink. Initial any changes. Do Not Erase. Employer Name: Division/Subsidiary Name (If Applicable): Policy No.:____ Mailing Address: _____ City: _____ State: ____ Zip: _____ Benefits Contact Person: Telephone Number: _____ Employee Name: Date of Hire: _____ Employee Base Annual Earnings (BAE): \$ _____ PROPOSED INSURED INFORMATION **Applicant Section** Personal Health Application BEFORE MAILING Please print in blue or black ink. Mail the completed Policyholder and Applicant section to: Initial any changes. Hartford Life and Accident Insurance Company Group Medical Underwriting • Answer all the questions and DATE and SIGN this form in all P.O. Box 2999 Hartford, CT 06104-2999 areas indicated. • Keep a copy for your records. Employee's Name (First, Middle Initial, Last): ☐ Male ☐ Female Height: ___ ft. ___ in. Weight: ____lb. Social Sec. No.: Mailing Address: Street: _____ City: ____ State: ___ Zip Code: ____ Phone Number (Daytime): Phone Number (Evening): Date of Birth: Occupation:

Email:

Who requires	s an Applic	cation										
		plicant who red						d specify	the reason	(s) why:		
	asons that	apply. Ident	ify any App	olicants re	quiring an	Applicat	ion.					
EE	☐ New	Hire		□ Op	ting up to	Higher L	evel of	☐ La	ate Entrai	nt		
Employee	coverage Issue lim	ired employee above the Gu and during their y period.*	arantee	Emplo	Coverage Employee electing an increase in life benefit as allowed by the plan.*		Employee electing coverage who previously did not elect within past eligibility periods.*					
SP			1	_			4 T	,				
Spouse	Spouse of first time Issue lim	Newly Eligible Dependent Spouse coverage elected for the first time above the Guarantee Issue limit during their initial eligibility period.*		Covera Spouse	☐ Opting up to Higher Level of Coverage Spouse coverage elected for an increase in life benefit.*			☐ Late Entrant Spouse coverage not previously elected within past eligibility periods. *				d
СН		ly Eligible De	pendent	□ On	☐ Opting up to Higher Level of			□ L:	ate Entrai	nt		
Child	Child coverage elected for the first time above the Guarantee Issue limit the during eligibility period.*		Covera Child o	~ -					not previously bility periods.			
	to your Po	olicy and emplo for salary incr	oyee records	s for cover	age amount	s, eligibili	ity periods	(for Late)	Entrant de	termination),	Guarant	eed
Applicants :	Requiring	Health Evaluat	tion (This is	critical in	formation a	nd if left b	olank there	will be a	delay in pr	rocessing)		
List below th	e names of	f Applicants id	lentified in F	Policyhold	er Section 1							
First Name,	, MI, Last l	Name	APPLIC	CANTS	HEIG (ft/in requir	1)	WEIGH (lbs) require			F BIRTH uired	GEN	DER
			Emp	loyee	ft	in	I	bs	/	/ 19	M	F
			Spo	use	ft	in	I	bs	/	/ 19	M	F
			Ch	ild	ft	in		bs	/	/ 19	M	F
If Depender	nt Coverage	e is desired, co	omplete the f	following:								
	Full N	Vame			Relations	ship		Birth	Date	Height	Wei	ght
						, nue on	3.5.4 ETT 0.3.4			l		
			U	THER IN	SURANCI	LINFOR	MATION					
Does anyone	proposed	for coverage h						ny other co	ompany?			
Does anyone Yes		for coverage h	ave any Life					ny other co	ompany?			
•	No If y		ave any Life		e in force or	pending i			ompany?	To be re	placed?	
☐ Yes ☐	No If y	es, give details	ave any Life	e Insurance	e in force or	pending i	in this or ar				~	
☐ Yes ☐	No If y	es, give details	ave any Life	e Insurance	e in force or	pending i	in this or ar				~	,

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By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance?

Yes No

COVERAGE REQUESTED

COVERAGE REQUEST	ED: New Coverage	Change in Coverage	
Monthly Benefit Amount	:: Payment Period Opti	on: Waiting Peri	od Option:
Is the Monthly Benefit A You: ☐ Yes ☐ 1	mount herein applied for equal to or less t No Spouse: Yes No	han [] of your Basic Monthly Pay n	ninus any Other Income Benefits?
Amount Desired [J		
		Please indicate if request is for	☐ New Coverage
	Proposed Insured		☐ Change in Coverage
	Spouse	The Spouse may not be covered until the Member's Plan.	der a Plan with benefits greater than
life coverage. Refer to e	For each Applicant, come to include any inforce Basic Life coverage employee records for Current Coverage Amount increments for increment plans.	ge as a dollar amount value for all App	
Applicants for Life Coverage	Current Coverage Amount (This includes any GI coverage if eligible. This would apply to new hires electing for the first time. If late entrant this amount should be zero.)	Additional Amount Applied For (This amount reflects only the amount to be medically underwritten)	Total Coverage (Combined total of the amount currently in force and the amount being underwritten)
Employee: Suppl. Life or Voluntary Life	\$,	\$,	\$,
Salary multiples for BAE plans	□ 0x □ 1x □ 2x □ 3x □ 4x x Other multiple	☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x x Other multiple	☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x x Other multiple
Employee: Basic Life	Required if Basic Coverage offered \$,	\$,	\$,
Salary multiples for BAE plans	□ 0x □ 1x □ 2x □ 3x □ 4x x Other multiple	☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x x Other multiple	☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x x Other multiple
Spouse: Basic Life	\$,,	\$,,	\$,,
Suppl. Life or Voluntary Life	\$,	\$,	\$,
Child: Basic Life	\$,,	\$,	\$,,
Suppl. Life or Voluntary Life	\$,	\$,	\$

Questions? Call 1-800-331-7234

The following costs were cal information to Hartford Life			your [] and [e contact your benefits		s. Your employer gave this nediately if it is incorrect.
Voluntary Long Torm Dis	ability Insurance				
You have the opportunity to work and is designed to begin	enroll in [nce helps to replace you with income protection		re sick or injured and cannot].
☐ I elect to enroll in the Vo	oluntary LTD plan at a	a monthly cost of [S	*]		
☐ I elect to decline the Vol	untary LTD plan.				
*Your cost may change if yo	ur salary changes with	nin the benefits pla	n year.		
The following costs were cal and Accident Insurance Com					information to Hartford Life
Voluntary Short Term Dis	sability (STD) Insui	rance			
You have the opportunity to work. This coverage comme	enroll in []. STD insurance h	nelps to replace your inco provides you with inco		ck or injured and cannot eplace up to [].
☐ I elect to enroll in the Vo	oluntary STD plan at a	weekly cost of [\$	*]		
☐ I elect to decline the Vol	untary STD plan.				
*Your cost may change if yo	ur salary changes duri	ing the plan year.			
G 1 / 17'6 7	T 1				
Supplemental Life Insura You have the opportunity to exceeds the lesser of [Insurance Company before the level of participation in this p	enroll in []], you will nee ne excess benefit can b	ed to provide evidence become effective.	The guaranteed issue an	is satisfactory to H	If you elect an amount that Hartford Life and Accident se as it is subject to the final
	Employee	Monthly	Employee	Monthly	7
	Life Amounts*	Cost*	Life Amounts*	Cost*	
To determine the cost for Supcost for [].	pplemental Life cover	age in excess of [] that yo	u wish to elect. Fo	or example, to calculate the
☐ I elect to enroll in the Su	pplemental Life plan	for \$ Employee Li	at a monthly	y cost of \$	·*
☐ I elect to decline the Sup	plemental Life plan.				
*Note: Benefit reductions be reduced benefit amount, not		you are or over the ount shown. Please			re calculated based on your er information.

Sup	oplemental Life Insi	urance – Sp	oouse							
[ou elect the Supplemental S	_]. Use	the rate cha	art and cal				. [Monthly cost for thi	is
	Spouse Life Amoun			onthly Cost*	Lif	Spouse e Amounts*		Monthly Cost*		
	I elect to enroll in the	Supplement	tal Life plan for \$	Spouse Life		nt a monthly c	ost of \$		ķ	
	I elect to decline the S	Supplementa	ıl Life plan for my	Spouse.						
*Yo	our cost may change if	your age cat	tegory changes w	ithin the ben	efits plan	year.				
	SPOUSE: First Nam	e	Last Na	me	Gender	Date of Mar	rriage	Date of Birth	Benefit Amount	ŧ I
	2 22 50 7 (1022)	•	21000 1 (0.		GULAUCI		2280		2000200 1211100020	
Supplemental Life Insurance - Child(ren) If you elect the Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) [You may elect []. Use the calculation line to determine your monthly cost for this coverage. [].										
		Child Life								
Cost per Child ☐ I elect to enroll my dependent child(ren) in the Supplemental Life plan for \$ at the monthly cost below. ☐ x = \$										
	I elect to decline the S	Supplementa	l Life plan for my	dependent	child(ren).					
	CHILD:					1				_
	First Nam	e	La	st Name		Gender	Date	e of Birth	Benefit Amount	-
										7

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BENEFICIARY INFORMATION

Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:

Contingent:

- Mary J. Doe, Wife (not Mrs. John Doe).
- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
Contingent						

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Beneficiary – Print full name & relationship to you		
Name_	Relationship	
The Proposed Insured will be the beneficiary for any Depend	dent Coverage desired.	

HEALTH INFORMATION

Health Questions

Questions 3-5, 7, 8, 11-13, 15-20 are to be answered by all Applicants listed above.

PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS ON THE NEXT PAGE:

Has anyone proposed for coverage been actively eng	aged in the full-time duties of his or her occupation during the 90 day period
immediately before the date of this application?	Employee: Yes No Spouse: Yes No
2. At any time during the past 12 months to the present,	has anyone proposed for coverage smoked cigarettes, cigars, or used a pipe,
1 1	
chewing tobacco, nicotine chewing gum or snuff?	Employee:
3. During the past 5 years have any of the Applicants at any of the following:	any time been treated or consulted a physician for, or told they have a problem with,
Chest pain, high blood pressure, elevated cholesterol,	heart murmur, abnormal pulse, blood or circulatory or vascular
conditions?	
Tumor, leukemia, skin disorders, moles, melanoma, ba	
Thyroid, spleen, any disease or disorder of the glands?	
Asthma, bronchitis, pneumonia, respiratory problems,	
Ulcer, liver, stomach, colitis, rectum, intestines, gallbl	adder, upper or lower digestive system?
Kidneys, bladder, or urinary tract - chronic?	
Genital or reproductive organ problems?	
Drug abuse, alcoholism, drug or alcohol or nicotine us	
Immune system, lupus, anemia or other blood condition	
Any disease or disorder of the brain or nervous system	n, Parkinson's Disease, Alzheimer's, epilepsy?
4. During the past 5 years has anyone proposed for cove conditions or treatments listed below:	erage been diagnosed with, or had any symptoms due to any of the following
Heart-Related Surgery, Heart Attack	Crohn's Disease
Stroke	Kidney Failure, Dialysis
Heart Disease, excluding high blood pressure,	Hepatitis, excluding Hepatitis A
excluding heart murmur	
Blocked Arteries, arteriosclerosis, atherosclerosis,	Diabetes
aneurysm, deep vein blood clot	
Chronic Obstructive Pulmonary Disorder (COPD)	Knee Disorder, Injury or Surgery
Emphysema	Back or Neck Disorder, Injury or Surgery
Adjustment Disorder	Joint or Ligament Disorder, Injury or Surgery
Bipolar Disorder	Osteoporosis, Osteopenia
Depression (single episode)	Multiple Sclerosis (MS)
Depression (multiple episodes)	Amyotrophic Lateral Sclerosis (ALS)
Psychotic Disorders, Personality Disorders	Muscular Dystrophy (MD)
Other Mental/Nervous/Psychiatric Disorders	Arthritis
(including Anxiety)	
Cancer, excluding Basal Cell Carcinoma	Fibromyalgia
Cirrhosis	Chronic Fatigue Syndrome
Ulcerative Colitis	Sleep Apnea
5. Has anyone proposed for coverage ever been diagno	osed or treated by a member of the medical profession for Acquired
	ed Complex (ARC) or any other immune deficiency disorder?
	verage consulted any physician, surgeon, psychologist, psychiatrist or
	on this application; or been confined or treated in any hospital,
sanatorium or similar institution?	

	L QUESTIONS: at 5 years has anyon	e proposed for cove	erage:			
7. Consulted	or been examined b		· ·	ther than normal 1	physical exams or acute illness	
	flu or sore throat?		1:			
	b tests, x-ray, electrons, normal findings?	ocardiogram or oth	er diagnostic testing (other than those re	equested as part of routine	
<u> </u>	<u> </u>					
0 During the	nact 5 waare hae an	vone proposed for	coverage been hospita	lized for any con	dition?	
			d in a hospital due to			
11. Is anyone	proposed for cover	rage currently preg	nant? If yes, Name:	What was	your pre-pregnancy weight?	
			ion for any condition		1	
13. Please list	t any symptoms, inj	jury, birth defect, co	ongenitai defect, disea	ise or other disorc	ler not mentioned above.	
If you answere	ed "Yes" to any of the	he above questions.	please explain the de	tails.		
ii you unswere	a res to any or a	ne usove questions,	prease exprain the de	turis.		
					or any "Yes" answer. Explain natu	
Question Number	Name	Disorder or Reason	Dates To/From		ttacks, duration, severity, treatment physicians, hospitals, & date of ful	
Number	Name	Reason	Dates 10/110III	addresses of	physicians, nospitais, & date of ful	11ccovery.
Applicant nai	me(s):		Medical condit	cion:	Date of Diagnosis:	
Treatment/M	edication:		Date treatment	started:	Date of last treatment:	
					7	
Current Statu	s:				Date of last symptom:	
Physicians na	ame and complete a	ddress:				
Please provide	Primary Care Phys	cician's name and co	omplete mailing addre	ess:		
Simplified Me	edical Underwritin	g Questions				
14 During the	nast 5 years have v	ou been treated dia	ognosed or received m	nedical advice for	a heart attack, stroke, cancer, back	muscle
			e Deficiency Syndror		a near attack, stroke, cancer, back	, muscic,
•		-				
Emple	oyee 🛮 Yes 🗖	No Spouse	☐ Yes ☐ No			
					thfully. A misrepresentation on the Answering "Yes" to this question of	
					covered or are no longer requiring r	

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services, you may ask for reconsideration by completing a Personal Health Application. Please contact your HR department for this form.

Notice: Applicant is required to notify Hartford Life and Accident Insurance Company in writing of any changes in any Applicant and Condition between the date that Applicant signs this form and the date coverage is approved.	cant's
15. During the past 5 years, with the exception of a past pregnancy, has anyone proposed for coverage lost time from work for more than 2 consecutive weeks or 10 work days due to the same physical, mental, or emotional condition, disability, injury or sickness, within a 36 month period?	
During the past 5 years, has anyone proposed for coverage:	
16. Used any controlled substances with the exception of those prescribed by his or her physician?	
17. Received medical advice or sought treatment for illegal drug use or alcohol abuse?	
18. Been advised to reduce the consumption of drugs or alcohol?	
19. Been charged with operating a motor vehicle under the influence of drugs or alcohol?	
20. Is anyone proposed for coverage currently undergoing any diagnostic testing for symptoms without a final diagnosis or resolution?	
CERTIFICATION	
I hereby certify that all statements and answers contained herein, are full, complete, and true to the best of my knowledge and bunderstand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the within the contestable period if such misrepresentation materially affects acceptance of the risk. This information may be used Hartford Life and Accident Insurance Company for plan administration purposes to decide if the person(s) is/are eligible for contestable period.	e coverage, by the
Subject to the deferred effective date provision I understand that coverage will not become effective until Hartford Life and Ac Insurance Company grants it's underwriting approval. I do not receive temporary or conditional insurance coverage just becau an application and pay the first premium.	
I certify that I have received the Notice of Insurance Information Practices. I agree that this document and all its contents shall of my enrollment request for group benefits.	form a part
Applicant Confirmation	
I have been given the opportunity to enroll in []. I understand that if I decline now, but la enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and Accident Insurance Compa understand my request for coverage may be denied.	
I authorize my employer to make the appropriate payroll deductions from my wages []. I am not now disabled performing all the duties of my occupation on a full-time basis. My spouse is either actively at work or, if not employed, able the normal and customary activities of a person of like age and sex in good health.	
I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be	e in force.
Please print Employee Full Name (First and Last): Please print Spouse's Full Name (First and Last)	
EMPLOYEE'S SIGNATURE (required) or Legal representative to Employee DATE SIGNED SPOUSE'S SIGNATURE (required only if applying for coverage) Relationship:	GNED

AUTHORIZATION

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 to: its reinsurer(s); the Medical Information Bureau, Inc.; any other insurance company to whom I may apply for Life or 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 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 this authorization. This authorization expires 30 months from the effective date of my 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 wish to pay my premiums: Quarterly Semi-annually Annually		
I authorize premium deductions from my: ☐ MasterCard ☐ VISA Cardholder's Name: Card #: Expiration Date: Bank card payment option is not available in California.		
PRE-EXISTING CONDITIONS LIMITATION		
I further understand that any condition that is: excluded; or limited by the policy will not be covered under this policy at any time. I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the [] period prior to my effective date of coverage will not be covered until I have gone [] ending on or after my effective date of coverage without medical advice or treatment for that condition, provided that the condition is not specifically excluded or limited by the policy.		
FRAUD NOTICE		
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.		
This information may be used by the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company (for fully insure coverages) or my employer/administrator (for self-funded coverages) for plan administration purposes to decide if the person(s) is/are eligible for coverage.		
EMPLOYEE'S SIGNATURE (required) or Legal representative to Employee DATE SIGNED (required only if applying for coverage) Relationship:		

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Applicant Authorization (This section is very important. Your form cannot be processed without it.) Authorization to Disclose Protected Health Information

To Be Used To Determine Eligibility for Group Life and/or Disability Coverage (Group Life and Disability Income are not subject to the requirements of HIPAA)

Name of proposed insured (please print)	Date of Birth

I have applied for insurance under a Group Life and/or Disability Policy issued by Hartford Life Insurance Company and/or Hartford Life and Accident Insurance Company. To assess whether I am eligible for this insurance, these companies may require that I authorize disclosure of a copy of my health information. This authorization is intended to comply with the requirements under §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), effective April 14, 2003.

I authorize any: health plan, physician, medical or health practitioner, counselor, therapist, hospital, clinic, other medical or medicallyrelated facility, or other health care provider who has provided treatment, payment, or services to me or on my behalf within the last 10 years; insurance company; or reinsurance company, with which I have had coverage; the Medical Information Bureau, Inc. (MIB), and any consumer reporting agency (collectively, "Releasors"); to disclose to the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company Health Information about me. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company may disclose the Health Information: to their agents; to their employees; and to their representatives (collectively "Hartford"); my entire Health Information. Health Information means the entire medical file. This includes, but is not limited to: x-rays; photocopies of medical records, medical histories, physical, mental or diagnostic examinations and treatment notes, that relate to: 1) Pre-existing or current illnesses, sicknesses, disease, disabilities, disorders, accidents, injuries or any other health conditions, 2) Confinements in hospitals, medical facilities or medical clinics, 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners, 4) Drug use, alcohol use, or mental health information protected by Federal Law, 5) Counseling or therapy. Health information also means information on the diagnosis and treatment of mental illness. But, it excludes psychotherapy notes as defined by HIPAA. I understand that the MIB will only disclose health information to Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Hartford will use this information to underwrite my request for coverage; make eligibility, risk rating, policy issuance and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to any coverage I have applied for with Hartford.

By signing this Authorization, I acknowledge and agree:

- That any agreements I have made to restrict disclosure of my health information do not apply to this Authorization;
- That I am authorizing the Releasors to release and disclose my entire medical file, as described above, without restriction.

By signing this Authorization, I acknowledge that I understand the following:

- That health information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the Releasors' knowledge. Note that Hartford only will use this information to underwrite your request for coverage; make eligibility, risk rating, policy issuance and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to coverage you have applied for with Hartford.
- That if 1) I refuse to sign this Authorization to release my entire medical file; or 2) if this Authorization is altered by me in any way, Hartford may not be able to process my application for coverage.
- That, if 1) Hartford denies my request for coverage; and 2) this denial is based, in whole or in part, on health information obtained in connection with this Authorization; Hartford will not release this information to me unless otherwise authorized by the Releasors, including my physician or other medical professionals, that disclosed such information to Hartford unless required by law.
- That, if necessary, Hartford will send this Authorization to Releasors authorized to release health information about me.
- That Hartford will also provide me with written notice of Releasors to which Hartford sends my Authorization.
- That I have a right, at any time, to revoke this Authorization. To do so, I must send a written request directly to such Releasors. My revocation will not be effective: to the extent that action has been taken in reliance upon this authorization; or, Hartford otherwise has the right: to contest the policy; or a claim under the policy.
- That this Authorization will expire 30 months from the effective date of my coverage or if no coverage has been issued, one (1) year from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original.
- That I am entitled to a signed copy of this Authorization.

Signature of Proposed Insured or Proposed Insured's Personal Representative	Date

Description of Personal Representative's Authority or Relationship to Proposed Insured (Required if signed by Personal Representative.)



NOTICE OF INSURANCE INFORMATION PRACTICES

PLEASE READ AND RETAIN THIS NOTICE OF INSURANCE INFORMATION PRACTICES FOR YOUR RECORDS.

In order to properly underwrite and administer your application for insurance coverage, we must collect certain information concerning your insurability. You are our most important source of information, but we may also contact other sources such as medical professionals and institutions, employers and other insurance companies. While all information regarding your insurability will be treated as confidential, in some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

INVESTIGATIVE CONSUMER REPORTS

As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. You have the right to send a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

PERSONAL HISTORY INTERVIEW

To provide you, our client, with the best possible service, we may also conduct what we call a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the application information is complete. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

ACCESS, CORRECTION AND DISCLOSURE

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Also, please be advised that personal and confidential information collected by us may, in certain circumstances, be disclosed to third parties without authorization. A notice providing further description of the circumstances under which information about you may be disclosed and the types of persons and organizations to whom it may be disclosed will be sent to you upon your written request. If you desire further information or access to your personal information, please send your written request to: Hartford Life Insurance Company or Hartford Life and Accident Insurance Company, 200 Hopmeadow St., Simsbury, CT 06089.

Underwriting Companies: Hartford Life Insurance Company or Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies is Simsbury, CT.