

# Life Insurance Application for NCOA Members, Spouses & Dependents

• Use this application for between \$25,000 and \$100,000 of protection ONLY.



Policyholder Name: NCOA	Group Policy Number AGL-1827	Hartford Life and Accident Insurance Company • Simsbury, CT 06089
<b>PRIMARY INSURED:</b> Member's Name: _____ Address: _____ City: _____ ST: _____ ZIP: _____ Date of Birth: ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female Place of Birth (city/state/country): _____ Height : _____ Weight: _____ Phone Number: (____) _____ <b>SPOUSE (if applying)</b> Name: _____ Date of Birth: ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female Place of Birth (city/state/country): _____ Height : _____ Weight: _____		<b>Check the desired amount of Coverage:</b> <b>Member:</b> <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <b>Spouse:</b> <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 Upon attaining age 65 the benefit amounts will reduce to a maximum of \$100,000 <b>I wish coverage for my child(ren):</b> <input type="checkbox"/> <b>Member's Beneficiary</b> — Print Full Name and relationship to you: Name _____ Relationship _____ <i>The primary insured will be the beneficiary for any Spouse coverage issued.</i> By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? Member: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No
At 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? Member: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, amount used daily? _____ Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, amount used daily? _____		
PLEASE COMPLETE THE FOLLOWING:		
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), alcohol or drug abuse, cancer, or enlarged lymph glands?.....		
	<b>Primary Insured</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> 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 (see reverse for complete definition)? .....		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?.....		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please review your answers to these questions to be sure that you have answered them fully and truthfully. A misrepresentation on these questions could void your coverage. Answering "Yes" to any of these questions disqualifies you from acceptance for coverage at this time. I/we understand that coverage will become effective only after approval by the Company and receipt of the first payment of premium. 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 this form.		
<b>CERTIFICATION and AUTHORIZATION</b>		
I hereby certify that I have read all statements and answers in this application and that they are full, complete and true to the best of my knowledge and belief. I understand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the coverage, within the contestable period if such misrepresentation materially affects acceptance of the risk. I understand that coverage will not become effective until The Hartford <sup>1</sup> grants its underwriting approval. I agree that subject to the deferred effective date provision that no insurance coverage shall become effective unless: a) The Hartford grants its underwriting approval; and b) at the time of payment of the first premium, I am living, and my insurability remains the same as that described in the application. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium. I certify that I have received the Notice of Insurance Information Practices. I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; consumer reporting agency; Medical Information Bureau, Inc., or employer; to give The Hartford or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status. The Hartford will use the information to decide if and to what extent I am 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: 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 the authorization. This authorization expires two (2) years 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. 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. The issuing company is shown on the face page of this application. AIDS Related Complex (ARC)* is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythematosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.		
X _____ Signature required to activate coverage	_____ Date	X _____ Spouse Signature, if applying
	_____ Date	

Underwritten by: Hartford Life and Accident Insurance Company  
Simsbury, CT 06089.

GBD-1000Assoc A (TX) (AGL-1827)  
FORM PA-9199 (1827)(HLA) SI-Life Q2)  
NCTL-708-0

The Hartford is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Company and Hartford Life Company.

**Choose payment method: (3 options)**

First month paid by check or money order enclosed, payable to The Hartford, I understand I will be billed on a quarterly basis.

Monthly through Credit Card

Visa  MasterCard  NCOA MasterCard

Acct#: \_\_\_\_\_

Exp.: \_\_\_\_\_

Monthly through Automatic Bank Withdrawal (see ABW form)

Sign, date and return with your Confirmation Form and a check for first month's payment. Your bank will make future payments automatically from this checking account.

Use this form to Activate ABW

Automatic Bank Withdrawal Request & Authorization  
As a convenience to me, I authorize The Hartford Financial Services Group, and/or its affiliates companies\* to withdraw funds from my account. I also authorize you, my financial institution, to pay from my account any checks, drafts or pre authorized electronic fund transfers from my account to the appropriate Company(ies) below.

X \_\_\_\_\_ / / .  
Your Signature as Shown on the Account Date

X \_\_\_\_\_ / / .  
Joint Account or Other Authorized Signature Date

\*The Hartford Financial Services Group • Hartford Life and Accident Insurance Company

Please mail your completed application form and first premium payment to: The Hartford, PO BOX 1197, Minneapolis MN 55440-9546

**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.