For Members of the American Occupational Therapy Association

DISABILITY INCOME INSURANCE APPLICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Hartford, Connecticut 06155

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:

AOTA GROUP INSURANCE PROGRAM
P.O. Box 10374
Des Moines, IA 50306-8812

QUESTIONS?

Call: 1-800-503-9230
E-Mail: customerservice.service@mercer.com

Section 1

Association Name: American Occupational Therapy Association	Policy No.: AGP-5841	Certificate No.: (Leave Blank)

Section 2

Name: (First, Middle Initial, Last)		❑ Male ❑ Female	Height: ____ft. ____in. Weight: ______lb.
Street:	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Age Last Birthday:	Place of Birth (State/Country):	
Daytime Phone No.: ( )	Business Telephone: ( )	Email Address:________________________	
Occupation:		Pre-Disability Earnings: $__________________	
Business Address: Street:			
City:		State:	Zip Code:
Beneficiary – Print full name & relationship to you Name:______________________ Relationship:______________________			

PA-9357 (HLA) (CA) (2-12)

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Section 3

Spouse/Domestic Partner's Name (First, Middle Initial, Last), if applying		❑ Male ❑ Female	Height: ____ft. ____in. Weight: ____lb.	
Street:	City:		State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Age Last Birthday:		Place of Birth (State/Country):	
Spouse's/Domestic Partner's Occupation:				
Daytime Phone No.: ( )		Business Telephone: ( )		
Pre-Disability Earnings: $__________________				
Business Address: Street:				
City:	State:		Zip Code:	
Beneficiary - Print full name & relationship to you Name ______________________________ Relationship ______________________________				

Section 4

COVERAGE REQUESTED:

Member Coverage:

❑ New Coverage: Monthly Benefit Amount: $____________________

Waiting Period: ❑ 60 days ❑ 90 days ❑ 180 days

❑ Change in Coverage:

Increase my Monthly Benefit Amount to: $____________________

❑ Change in Waiting Period:

❑ 60 days ❑ 90 days ❑ 180 days

Spouse/Domestic Partner Coverage:

❑ New Coverage: Monthly Benefit Amount: $____________________

Waiting Period: ❑ 60 days ❑ 90 days ❑ 180 days

❑ Change in Coverage:

Increase my Monthly Benefit Amount to: $____________________

❑ Change in Waiting Period:

❑ 60 days ❑ 90 days ❑ 180 days

Section 5

Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company? ❑ Yes ❑ No

If yes, give details:

Name	Company	Monthly Benefit	Benefit Period	Waiting Period	To be replaced? Yes	 No

Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 25 hours per week) 90 days before the date of this application? You: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Pre-Disability Earnings minus any Other Income Benefits? You: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

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Section 6

	Member YES/NO		Spouse/ Domestic Partner YES/NO	
All questions are answered to the best of my knowledge and belief:				
1 In the past 10 years, 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 disorder or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system?	❑	❑	❑	❑
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, excluding HIV tests?	❑	❑	❑	❑
2 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 been confined or treated in any hospital, sanatorium or similar institution?	❑	❑	❑	❑
3 Is anyone proposed for coverage now pregnant?	❑	❑	❑	❑
If yes, Name: ______________________________				
When is the baby due? ____________________				
What was your pre-pregnancy weight? ____________				
Are there any medical complications?	❑	❑	❑	❑

Section 7

If you answered "Yes" to any of the above medical questions, please explain the details below.

Question Number and Condition	Name of Family Member	Dates	For any question answered "yes" please provide details, your physician's name, full address, and phone number (Required for processing)

(Attach sheet of paper if additional space is needed. Sign and date additional sheet of paper.)

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Section 8

AUTHORIZATION

I hereby certify that I have read or have had read to me 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 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 submit an application and pay the 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 physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage.

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

I authorize 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 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.
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.

PRE-EXISTING CONDITIONS LIMITATION: I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until one (1) year after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation. I further understand that any condition excluded or limited by the policy or by a Health Waiver attached to my certificate will not be covered under this policy at any time.

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

I wish to pay my premiums: ❑ Automatic Monthly Check Withdrawal ❑ Semi-Annual Direct Bill
(If you select Automatic Monthly Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

Section 10

Member's signature (Sign name in full) ___________________________ Date___________________________
Required Required

Spouse/Domestic Partner's signature (if applying) ______________________________ Date_________________________
Required Required

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 may be guilty of a crime and may be subject to fines and confinement in prison.

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Domestic Partnership Affidavit

Name of Applicant ____

Name of Domestic Partner ____

The undersigned member and domestic partner, being of sound mind, hereby state the following:

1. That the undersigned member and domestic partner have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations and that this commitment is of at least six months duration and is expected to continue indefinitely.

2. That the undersigned member and domestic partner share a single permanent residence (attach one copy of evidence such as driver's license).

3. That the undersigned member and domestic partner are financially interdependent as demonstrated by at least two of the following (check all that apply and attach copy of evidence):

- ❑ Common ownership of a motor vehicle.
- ❑ Joint bank or credit accounts.
- ❑ Assignment of durable power of attorney in favor of one another.
- ❑ Common ownership of real estate or common leasehold interest in property.
- ❑ Joint ownership or holding of stocks, bonds, or other investments.
- ❑ Execution of will naming each other as executor and/or beneficiary.
- ❑ Designation as beneficiary under the other's retirement or pension benefits account.

4. That the undersigned member and domestic partner (check one):

- ❑ have filed a domestic partner declaration with the (City/Council/Borough) of________________ and that such domestic partner declaration remains in effect (attach copy of declaration).
- ❑ do not reside in a jurisdiction which provides for the registration of domestic partnership declarations.

5. That neither the undersigned member nor domestic partner would be able to affirm questions 1 through 4 above with respect to any person except the other.

6. That neither the undersigned member nor domestic partner has executed or filed a declaration or affidavit of domestic partner status with any other person within the past 12 months.

7. That the undersigned member and domestic partner are each no less than 18 years of age, and are under no legal disability which would prevent them from making this affidavit.

8. That neither the undersigned member nor domestic partner are now, or have been within the past six months, married to any other person, including common law marriage.

9. That the undersigned member and domestic partner are not related by blood in any degree which would prevent their marriage to each other.

The undersigned member and domestic partner represent that the statements made herein are true and correct to the best of their knowledge, information and belief. Member and domestic partner understand that these statements are given for the purpose of establishing their eligibility and understand that any misrepresentation, whether or not made with intent to deceive, may result in the ineligibility of the domestic partner for coverage under such policy, and in the voiding of such coverage. The member and domestic partner agree to furnish upon the Company's request evidence to substantiate any statement made herein, and that the Company may require the member and/or domestic partner, if living, to reaffirm all statements made herein periodically and/or when a claim is submitted. In the event any coverage is voided due to any misrepresentation herein, the Company's liability shall be limited to a return of any premiums paid on behalf of the domestic partner for any period of ineligibility.

Applicant's Signature____ **Date**___________________

Domestic Partner's Signature____ **Date**____________________

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AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account #: ____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: ________________________________ **Date:** ____________________________________

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Disability Income Insurance Plan

Don't Let A Disabling Injury or Sickness Harm Your Family's Financial Security…

Help make sure your financial future is secure with Disability Income Insurance

Up to $5,000 in Monthly Benefits

Member and/or Spouse/Domestic Partner under age 65, who have been Actively at Work (at least 25 hours per week), may apply for up to $5,000 per month in disability income benefits. A Spouse cannot be legally separated or divorced from the Member.

This coverage is available only for residents of the United States excluding AR, FL, ID, LA, ME, MD, MT, NM, NY, OR, TX, WA and WV.

Choose Your Monthly Benefit

You may choose benefit amounts from a minimum of $200 up to $5,000 in $100 increments per month (your benefit amount cannot exceed 60% of your Pre-disability Earnings minus any Other Income Benefits). Once Totally Disabled, benefits will begin on the first day following completion of your selected Waiting Period (60, 90, or 180 days).

This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the Policy:

Insured's Gross Monthly Income	$3,000.00
Long term disability benefits percentage	x 60%
Unreduced maximum benefit	$1,800.00
Less Social Security disability benefit per month	- $900.00
Less state disability income benefit per month	- $300.00
Total amount of long term disability benefit per month	$600.00

Benefit Period

For Total Disability caused by a covered Sickness or Injury, benefits will be paid as follows:

Up to age 65 if Total Disability occurs before attainment of age 64. If Totally Disabled at ages 64 through 69, benefits will be payable up to 12 months, but not beyond age 70.

Recurrent Disability

In order to requalify for full benefit periods, each disability period must either be separated by at least 6 consecutive months during which the insured is Actively at Work, or the later Total Disability is caused by an unrelated cause.

Rehabilitative Employment Benefit

If, while you are Totally Disabled, you accept Rehabilitative Employment, you will continue to receive a Monthly Benefit Amount.

The Monthly Benefit Amount will be equal to your Injury and Sickness Total Disability Monthly Benefit Amount, less 50% of any income received from the Rehabilitative Employment.

The sum of the Monthly Benefit Amount and total income received from a program of Rehabilitative Employment may not exceed 100% of your Pre-disability Earnings. If this sum exceeds the Pre-disability Earnings, the Monthly Benefit Amount paid will be reduced accordingly.

Survivor Income Benefit

Your beneficiary will receive a one-time survivor benefit payment if you die after Total Disability has continued for at least 6 months; while receiving a Monthly Benefit; and the Maximum Benefit Period has not been exhausted under the Injury and Sickness Total Disability Benefit; a Survivor Income Benefit Amount is equal to three times your last Monthly Benefit Amount. Your "Last Monthly Benefit Amount" will not include any reduction for wages earned while in rehabilitative employment.

Coordination of Benefits

The benefits will be coordinated with any other benefits you are entitled to receive from: Workers' Compensation or other similar legislation; occupational disease laws; state disability benefits or other governmental legislation; employer-endorsed disability plans; disability or early retirement benefits received under the employer's pension plan; Social Security disability or Civil Service disability benefits. In no event will the monthly benefits paid under this plan plus the income from the above sources exceed 60% of your Basic Monthly Pay at the time you become Totally Disabled.

Effective Date

Your insurance will become effective on the first of the month following the date of approval of your application, provided the required premiums are paid. If you are to become covered under the Policy, or covered for increased benefits under the Policy and you are not Actively at Work on the date your coverage is to become effective, you will not be covered until the first day of the month on or next following the date you are Actively At Work for 1 month. Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford[1]. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s), or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience and at no expense to you.

Termination of Coverage

Coverage continues as long as: you remain an association member; you pay your premiums on time; you remain Actively at Work (except by reason of Total Disability covered by this plan); the master policy is in effect; and you remain under 70. Your spouse/domestic partner's coverage will remain in effect as long as your coverage is active, premiums are paid, and they meet the eligibility requirements.

TERMS OF COVERAGE

Exclusions

No benefits will be paid for any disability which is within or results directly or indirectly from one of the following: 1) intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane; 2) pregnancy or childbirth, except Complications of Pregnancy; 3) war or act of war, whether declared or not; 4) the commission or attempted commission of a felony by you; 5) Sickness contracted or Injury sustained while on full-time active duty as a member of the Armed Forces (land, water, air) of any country or international authority (orders to active service for a period of 30 days or less will not be considered full time active duty in the military); 6) any Injury sustained while riding on, boarding or alighting from, any aircraft: a) as a pilot, crew member or student pilot; b) operated by any military authority (land, sea or air), unless it is a Military Transport Aircraft used for transport and operated by the United States Military Air Mobility Command (AMC) or an AMC type service of a national government recognized by the United States; or c) being used for tests, experimental purposes, stunt flying, racing or endurance tests.

Mental Nervous Disorder Limitation

If you are Totally Disabled due to Mental or Nervous Disorders, alcoholism or drug abuse, the Maximum Payment Period will be reduced to 2 years during your lifetime unless you are confined in a hospital or other institution licensed to provide care and treatment for that Total Disability.

Defined Terms

Injury means bodily injury which results directly from accident and independently of all other causes.

Total Disability means a disability which, during the waiting period and the first 60 months of Total Disability, wholly and continuously prevents you from performing the substantial and material duties of your own occupation.

Pre-disability Earnings means your regular monthly rate of pay, not counting commissions, bonuses, overtime pay or any other fringe benefit or extra compensation, in effect on the last day you were Actively at Work prior to becoming Totally Disabled.

Waiver of Premium

If you become Totally Disabled, and the Total Disability continues for more than 6 consecutive months, you won't have to pay your premiums for as long as the Total Disability lasts and benefits are payable.

Monthly Rates per $100 Monthly Benefits

Select the monthly income you need, from $200 to $5,000.

Premiums are based on your selected Waiting Period, age when entering the program, and changes as each new age bracket is reached. The Insurance Company reserves the right to change rates.

Monthly* Premiums per $100 Benefit Unit

(Maximum $5,000 a month or 60% of your Pre-disability Earnings)

	Waiting Period		
Your Age	**60 days**	**90 days**	**180 days**
Under 30	$1.33	$1.17	$0.96
30–39	1.60	1.33	1.17
40–49	2.48	2.08	1.83
50–59	4.17	3.58	3.17
60–69**	6.74	5.71	5.04

Rates and/or benefits are subject to change on a group basis.

*All Premiums apply at attained age on each premium due date.

**Only those under 65 may apply. Renewal Rates Only.

Rates are based on the attained age of the Insured Person and increase as you enter each new age category.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

Pre-Existing Conditions Limitation

During the first two years of coverage, losses incurred for Pre-Existing Conditions are not covered. A Pre-Existing Condition means any Injury or Sickness including pregnancy; diagnosed or undiagnosed, for which you have received medical care within the 12-month period prior to your coverage effective date or the date of an increase in coverage. During that time, benefits for all other accidents or illnesses will be paid under the policy provisions. You are urged to consider this limitation before dropping any coverage you may have until the Waiting Period is over.

It's Easy to Apply!

1. Complete, date and sign the enclosed Application. If your spouse/domestic partner is also applying, please complete the form and sign where indicated.
2. **Send no money now.** You will be billed when your Certificate is issued.
3. Mail your completed Application in the enclosed return envelope for approval.
   Mercer Consumer,
   P.O. Box 10374
   Des Moines, IA 50306-8812

Administered by:

MERCER
MAKE TOMORROW, TODAY

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
P.O. Box 10374
Des Moines, IA 50306-8812

1-800-503-9230
www.aotainsurance.com

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

Underwritten by:

THE HARTFORD

Hartford Life and Accident Insurance Company
Hartford, CT 06155

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This brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Hartford Life and Accident Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder.

Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

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NOTICE OF INSURANCE INFORMATION PRACTICES

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 – NOT APPLICABLE TO RESIDENTS OF NEW YORK

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.

MEDICAL INFORMATION BUREAU (MIB) PRE-NOTICE

Information regarding your insurability will be treated as confidential. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company, with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, or their reinsurers, may also release information from their files to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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.

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