For Members of the University of California/Los Angeles Alumni Association

DISABILITY INCOME INSURANCE APPLICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Simsbury, Connecticut 06089

THE HARTFORD

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

UCLA Alumni

Section 1

Association Name: University of California/Los Angeles Alumni Association	Policy No.: AGP-5636	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:	Basic Monthly Pay: $_____		
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/Domestic Partner's Occupation:			
Daytime Phone No.: ( )	Business Telephone: ( )		
Basic Monthly Pay: $_____			
Business Address: Street:			
City:	State:	Zip Code:	
Beneficiary - Print full name & relationship to you Name:_____ Relationship:_____			

Section 4

COVERAGE REQUESTED:

Member Coverage:

Plan I Option 1: Waiting Period: ❑ 30 days ❑ 60 days ❑ 90 days ❑ 180 days
Plan I Option 2: Waiting Period: ❑ 30 days ❑ 60 days ❑ 90 days ❑ 180 days
Plan II: Waiting Period: ❑ 30 days ❑ 60 days ❑ 90 days ❑ 180 days

Plan I Option 1 Payment Period: ❑ to age 65
Plan I Option 2 Payment Period: ❑ to age 65
Plan II Payment Period: ❑ 2 years

❑ New Coverage: Monthly Benefit Amount: $_____

❑ Change in Coverage:
Increase my Monthly Benefit Amount to: $_____

SPOUSE/DOMESTIC PARTNER COVERAGE:

Plan II: Waiting Period: ❑ 30 days ❑ 60 days ❑ 90 days ❑ 180 days

Plan II Payment Period: ❑ 2 years

❑ New Coverage: Monthly Benefit Amount: $_____

❑ Change in Coverage:
Increase my Monthly Benefit Amount to: $_____

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 30 hours per week) 90 days before the date of this application? You: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

If you're applying for Plan I Option 1, is the Monthly Benefit Amount herein applied for equal to or less than 70% of your Basic Monthly Pay minus any Other Income Benefits? ❑ Yes ❑ No

Section 6

All questions are answered to the best of my knowledge and belief:		Member YES/NO	Spouse/ Domestic Partner YES/NO
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

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.

QUESTIONS?
Call: 1-888-560-2586
E-Mail: customerservice.service@mercer.com

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

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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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UCLA Alumni

UCLA-Sponsored Disability Income Insurance Plan

Help protect your most valuable asset—Your income with

up to $10,000 per month in Disability Insurance

- **Your Choice of 2 Plans**
- **Your Choice of Waiting Period**
- **Spouse/Domestic Partner Coverage Available**
- **Benefits paid for Rehabilitative Employment, Paraplegia, Partial Disability and more**
- **30-Day Satisfaction Guarantee**

See inside for details
(including costs, exclusions, limitations and terms of coverage).

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Help safeguard your family's financial future - Help protect your income with the UCLA Alumni-sponsored Disability Income Insurance Plan.

Why Is Disability Insurance a Good Choice?

Disability Income Insurance is often considered a very affordable way to help assure yourself and your family a stable income if you become Totally Disabled.

Disability Income Insurance helps pay the bills after any short-term benefits are depleted. You also have the option of having your choice of coverage, so you can create the best income protection plans for yourself and your family.

Who May Apply?

All members under age 65, Actively-at-Work (at least 30 hours per week), and residents of the U.S. may apply for up to $10,000 per month in benefits. A spouse/domestic partner (if not legally separated or divorced from the member) who meets these same requirements may also apply for up to $2,000 under Plan II. May not be available in all states. Please contact your program administrator for details.

Plan I Option 1: The benefit amount you apply for under this option, in combination with all Other Income Benefits, must not exceed 70% of your Basic Monthly Pay. Benefit amounts available beginning at $100 to $4,900 in $100 increments.

Plan I Option 2: The benefit amount you apply for under this option, in combination with all Other Income Benefits, must not exceed 50% of your Basic Monthly Pay. Benefit amounts available beginning at $5,000 to $10,000 in $100 increments.

Plan II: The benefit amount you apply for under this option, in combination with all Other Income Benefits, must not exceed 75% of your Basic Monthly Pay. Benefit amounts available beginning at $500 to $10,000 in $100 increments.

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 Basic Monthly Pay	$3,000
Disability benefits percentage	x 70%
Unreduced maximum benefit	$2,100
Less Social Security disability benefit per month	- $900
Less state disability income benefit per month	- $300
Total amount of disability benefit per month	$900

Offset Provision

The Offset Provision means the benefit amount payable as the result of the Insured Person's Total Disability will be the lesser of the Monthly Benefit Amount or the Monthly Benefit Amount minus any Other Income Benefits. However, if the Insured Person's Monthly Benefit Amount would reduce to less than $50.00 per month due to the Other Income Benefits, then the minimum Monthly Benefit Amount under this benefit will be $50.00 per month. Other Income includes any such benefits for which you are eligible or that are paid to you, or to a third party on your behalf, for: Workers' Compensation; employer or government plan; "no-fault" automobile insurance or Social Security.

Basic Monthly Pay 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 of Active employment prior to becoming Disabled. See your Certificate of Insurance for information if you are self-employed.

When Would Benefits Begin?

The choice is yours ... benefits can begin after 30, 60, 90 or 180 days of Total Disability. Choose a Waiting Period that best suits your needs by comparing your current savings versus your expenses. If your savings can meet only one or two weeks' worth of expenses during a disabling illness, then consider selecting the 30-day Waiting Period. However, if you feel that you can meet your expenses for a longer period of time, then consider choosing a 60, 90 or 180-day Waiting Period.

How Much Coverage Should You Consider?

No two families are alike. That's why this plan gives you the flexibility to choose a coverage amount that helps fit your lifestyle. You can select to receive anywhere from $100 to $10,000 ($2,000 for spouses/domestic partners) a month, subject to income ratios. Base your selection on your current income level and remember that you may have additional medical costs to cover.

What Benefits Would You Receive?

Plan I: Total benefits you receive from this plan and from Other Income Benefits (including Worker's Compensation, Social Security, employer-sponsored salary continuation, group or franchise plans or retirement programs) may not exceed 70% (50% if the monthly benefit amount applied for is $5,000 or more) of your current Basic Monthly Pay.

Plan II: Total benefits in combination with all Other Income Benefits in force or applied for may not exceed 75% of your Basic Monthly Pay.

How Long Would You Receive Benefits?

There are two plans to choose from ...

Plan I (for members only) ... if you are Totally Disabled by a covered Injury or Sickness, you will receive benefits beginning on the day after your Waiting Period and continuing until you reach age 65 (24 months if disabled after age 65) as long as you remain Totally Disabled.

Plan II (for members and spouses/domestic partners) ... if you are Totally Disabled by a covered Injury or Sickness, you will receive benefits beginning on the day after your chosen Waiting Period and continuing for up to two full years. Spouses/Domestic Partners can receive benefits up to a maximum of $2,000 per month.

Limitation for Mental or Nervous Disorders, alcoholism, or drug abuse *(Plan I Only)*

Benefits will be paid for Total Disability due to Mental or Nervous Disorders, alcoholism, or drug abuse if you are receiving psychiatric care at least twice a month for this Disability. Benefits will begin after the chosen Waiting Period and will continue for up to 24 months or to age 65, whichever occurs first. Thereafter, benefits will continue only if you are an inpatient in a hospital or institution and under a doctor's care.

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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, performing the full-time duties of your occupation.

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.

Managed Disability Approach

In the Hartford's[1] approach to Managed Disability emphasis is placed on abilities rather than disabilities and empowering people with disabilities so they're able to reach their full potential. The Managed Disability approach encourages a healthy lifestyle through prevention and wellness programs. When an individual becomes disabled, they are helped with rehabilitation and motivation to return to work as soon as reasonably possible.

Residual Disability Benefits *(Plan I Only)*

After the Waiting Period this benefit helps ensure that a portion of your regular monthly benefit will continue to be paid as long as you are gainfully employed and your income is less than 75% of your Pre-Disability Earnings, you are under age 64 and your benefit period has not expired. This assists you with income if you are still under a doctor's care, unable to perform all of your duties as the result of your disability.

Pre-Disability Earnings means the average monthly income received during the 12 months immediately preceding the Insured Person's Disability.

Rehabilitative Employment Benefits *(Plan I Only)*

If you accept Rehabilitative Employment you will receive monthly benefits for up to 60 months while Totally or Partially Disabled. You will receive your regular monthly benefit less 50% of any income earned from Rehabilitative Employment. Your vocational rehabilitation program will include staff nurses and specially trained counselors. Each individual rehabilitation program is custom tailored to each claimant's needs and aspirations. Our counselors use skills assessment, job and transferable skills analysis, job modification, vocational testing, job placement assistance, and retraining.

The sum of monthly benefit amounts and total income received from a program under rehabilitation employment may not exceed 100% of your Basic Monthly Pay.

Paraplegia Benefit

This benefit equals 10 times your chosen monthly disability benefit. It will be paid if you are under age 60 and have received Total Disability benefits for 12 consecutive months because both your upper or both your lower limbs are completely and irreversibly paralyzed.

Paraplegia Benefit is paid in addition to any other benefits provided. The complete and irreversible paralysis must be a result of an Injury or Sickness.

Partial Disability Benefit

You can receive 50% of your chosen monthly benefit if, because of a covered Sickness or Injury, you are unable to perform one or more of the important duties of your regular occupation, you are not receiving Total Disability or Residual Disability Benefits, and you are under the regular care of a physician. Partial disability benefits will be paid up to your maximum benefit period under Plan I after a seven-day Waiting Period. If the partial disability lasts for part of a month, you will receive a portion (1/60th) of your chosen monthly benefit for each day of partial disability. There is a seven-day Waiting Period for this benefit and it is payable for up to 180 days under Plan II.

Survivor Benefit

If the insured is Totally Disabled for more than 180 days, is receiving benefits immediately prior to their death and provided the maximum payment period has not been met, a payment equal to three times their selected monthly benefit will be paid to their spouse/domestic partner, if living. If not, it will be paid in equal shares to their living children or, if there are none, to their estate.

Total Disability Definition

Plan I – Total Disability means Disability which, during the first 24 months during which benefits are payable, wholly and continuously prevents the Insured Person from performing the substantial and material duties of his or her usual occupation; and thereafter wholly prevents an Insured Person from engaging in any and every occupation or employment for which he is reasonably suited by training, education, or experience.

Plan II – You will be considered Totally Disabled if you cannot perform the substantial and material duties of your occupation during your chosen Waiting Period and for the first 24 months thereafter.

Pre-Existing Conditions Limitation

Plan II Only – A Pre-Existing Condition is a health problem for which you have received medical advice or treatment during the 12-month period immediately preceding the effective date of your insurance. Disabilities caused by Pre-Existing Conditions will not be covered until you have had no medical advice or treatment for that condition for 12 consecutive months or you have been insured for 24 months.

Repeat Claims

Repeat disability claims due to different causes will be treated as separate disabilities, with a new Waiting Period and full benefit period. Repeat claims from the same cause will be treated as separate disabilities, with a new Waiting Period and full benefit period, if there are at least 90 days during which you are Actively-at-Work between disabilities. Otherwise, the benefits remaining under the original claim will be paid.

Concurrent Disabilities

Benefits during any Period of Disability as the result of: more than one sickness; or more than one accident; or both sickness and accident; will be considered the same as if the disability resulted from only one cause.

Exclusions and Limitations

This policy does not cover: intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane (in Missouri while sane); pregnancy or childbirth, except Complications of Pregnancy; war or act of war, whether declared or not; the commission or attempted commission of a felony by You; 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.

Continuing Coverage

Coverage can continue until you retire, are no longer Actively-at-Work, except due to disability, covered by the Policy, or reach age 70, as long as the association remains a member of the Trust, you remain a member of the association or spouse/domestic partner of a member, pay premiums, and the Master Policy is in force.

Waiver of Premium

If you become Totally Disabled before age 60, and the disability continues more than 6 consecutive months, you won't have to pay your premiums for as long as you are eligible for benefits.

Affordable Rates

Monthly Premiums per $100 Benefit

Plan I (For Members Only) ... Disability Protection to Age 65

Benefits begin on:	Under 30	30–39	40–49	50–59	60–64	65–69*
31st day	$1.38	$1.92	$3.18	$5.12	$5.43	$5.02
61st day	$1.13	$1.63	$2.63	$4.26	$4.46	$4.08
91st day	$0.89	$1.26	$2.08	$3.35	$3.33	$2.95
181st day	$0.81	$1.14	$1.89	$3.05	$2.75	$2.43

Plan II (For Members and Spouses/Domestic Partners) ... Disability Protection for Two Full Years

Benefits begin on:	Under 30	30–39	40–49	50–59	60–64	65–69*
31st day	$0.75	$0.98	$1.68	$3.36	$5.35	$6.52
61st day	$0.64	$0.84	$1.45	$2.89	$4.52	$5.50
91st day	$0.39	$0.53	$0.92	$1.63	$2.43	$2.95
181st day	$0.33	$0.43	$0.76	$1.34	$2.00	$2.43

*For renewal purposes only.

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

Rates and/or benefits may be changed on a class basis.

To Compute your Premiums: multiply the rate for your age by the number of $100 units you desire. To pay semi-annually, multiply your final monthly premium rate by 6.

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.

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How 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. If you are applying as Domestic Partner, please submit a completed Domestic Partnership Affidavit form.

2. Return application to:

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

Administered by:

MERCER

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

1-888-560-2586
www.alumniplans.com/ucla

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

Underwritten by:

THE HARTFORD

Hartford Life and Accident Insurance Company
Simsbury, CT 06089

[1]The Hartford® is The Hartford Financial Services Group, Inc. and it's subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

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. Polices underwritten by the Hartford Life and Accident Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the polices 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 Trustees of the Association and Society Group Insurance Trust. This program may vary and may not be available to residents of all states.

Form SRP-1311 AB (5636)
Policy Number AGP-5636

DI648P-AGP5636P
5/14

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

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