GROUP DISABILITY INCOME INSURANCE APPLICATION

THE HARTFORD

HARTFORD LIFE INSURANCE COMPANY
Simsbury, Connecticut 06089

UCLA Alumni

Section 1

Association Name: University of California/Los Angeles Alumni Association	Policy No.: AGP-5637	Certificate No.: (Leave Blank)

Section 2

Member Name:	☐ 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:_____ The Proposed Insured will be the beneficiary for any Dependent Coverage desired.		

Section 3

Spouse/Domestic Parter's Name: (First, Middle Initial, Last), if applying	☐ Male ☐ Female	Height: ___ft. ___in. Weight: _____lb.
Street:	City:	State: Zip :
Date of Birth (MM/DD/YYYY):	Age Last Birthday:	Place of Birth (State/Country):
Spouse/Domestic Parter's Occupation:		Basic Monthly Pay: $_____
Daytime Phone No.: ( )		Business Telephone: ( )
Business Address: Street:		
City:	State:	Zip Code:

Section 4

COVERAGE REQUESTED:

Member Coverage:

☐ New Coverage: Monthly Benefit Amount: $_____

☐ Change in Coverage:

Increase my Monthly Benefit Amount to: $ _____

☐ Change in Waiting Period:

Waiting Period: Plan 1A ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Plan 1B ☐ 30 days ☐ 90 days ☐ 180 days

Plan 2 ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Payment Period: Plan 1 ☐ Up to Age 65

Plan 2 ☐ 24 months

Spouse/Domestic Partner Coverage:

☐ New Coverage: Monthly Benefit Amount: $_____

☐ Change in Coverage:

Increase my Monthly Benefit Amount to: $ _____

☐ Change in Waiting Period:

Waiting Period: Plan 1A ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Plan 1B ☐ 30 days ☐ 90 days ☐ 180 days

Plan 2 ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Payment Period: Plan 1 ☐ Up to Age 65

Plan 2 ☐ 24 months

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) immediately before the date of this application? You: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No

If you're applying for Plan 1A, is the Monthly Benefit Amount herein applied for equal to or less than 70% of your Basic Monthly Pay minus any Other Income Benefits? You: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No

Section 6

	PLEASE COMPLETE THE FOLLOWING:	Member Yes	Member No	Spouse/ Domestic Partner Yes	Spouse/ Domestic Partner 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?	☐	☐	☐	☐

For residents of the State of New York, the maximum benefit amount is 50% for Plan 1B and 75% for Plan 2 of your Basic Monthly Pay.

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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, including dates, your physician's name, full address, phone number and fax number. (Required for processing)

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

Section 8

AUTHORIZATION

I/We hereby certify that I/we have read or have had read to me/us all statements and answers in this application, and in any other application or medical form required by Hartford Life Insurance Company, and that they are full, complete, and true to the best of my/our knowledge and belief. I/We understand that any material misrepresentations in this application could cause a claim to be denied under any insurance issued based on this application. I/We 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/We also agree that a copy of this application shall be attached to and form a part of any certificate issued. I/we also understand that the Company may request whatever additional evidence of insurability it needs.

Subject to the deferred effective date provision, I/We understand that coverage will not become effective until the Company grants its underwriting approval. I/We do not receive temporary or conditional insurance coverage just because I/we submit an application and pay the first premium.

I/We 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 Insurance Company or its legal representative information about my/our physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status except drug and alcohol treatment information.

Hartford Life Insurance Company will use the information to decide if and to what extent we are eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I/We understand the Medical Information Bureau, Inc. will release records or information only to Hartford Life Insurance Company.

I/We authorize Hartford Life Insurance Company to give information about me/us to any other insurance company to whom I/we 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/We authorize Hartford Life Insurance Company, or it's reinsurers, to make a brief report of my/our personal health information to Medical Information Bureau.

I/We understand that upon written request I/we 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/our coverage or, if no coverage has been issued one (1) year from the date of this application.

I/We understand that a photocopy of this form is as valid as the original, and that I/we have a right to receive a copy of this form upon request.

I/We certify that I/we have received the Notice of Insurance Information Practices. I/We agree that this document and all its contents shall form a part of my/our enrollment request for group benefits.

PRE-EXISTING CONDITIONS LIMITATION: I/We understand that any injury or sickness, diagnosed or undiagnosed, for which I/we have received medical advice or treatment in the 12 month period prior to my/our effective date of coverage will not be covered until I/we have gone 12 months ending on or after my/our effective date of coverage without medical advice or treatment for that condition, or until 1 year after my/our 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/our certificate. Applications to increase coverage will be subject to a new pre existing conditions limitation.

I/We further understand that any condition excluded or limited by the Policy or by a Health Waiver attached to my/our certificate will not be covered under this Policy at any time.

SECTION 9

I wish to pay my premiums: ☐ Automatic Monthly Check Withdrawal ☐ Semi-Annual Direct Bill ☐ 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

FRAUD WARNING STATEMENT

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 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

MERCER

Send Completed Form To:

ADMINISTRATOR
UCLA GROUP INSURANCE PROGRAM
P.O. BOX 10374
Des Moines, IA 50306-8812

QUESTIONS?

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

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

Disability Income Insurance Plan for Residents of New York

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 Rehabilitation, Survivor Income, Partial Disability and much 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 now- 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 an affordable way to help provide 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 may also have to dip into your savings as well; Disability Income Insurance helps minimize the impact to your hard-earned savings. The Plan provides you with up to $10,000 a month, to use as you'd like. You also have the option of having your choice of coverage, so you can create an income protection plan for yourself and your family.

Who May Apply?

All members under age 64, Actively-at-Work (at least 30 hours per week), and residents of New York 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 $10,000.

Plan I: The benefit amount you apply for under this option, in combination with all Other Income Benefits, must not exceed 70% for Plan 1A and 50% for Plan 1B of your Basic Monthly Pay. Benefit amounts for Plan 1A are $100 to $4,900 in $100 increments and benefit amounts for Plan 1B are $5,000 to $10,000 in $100 increments.

The 60-day Waiting Period is not available for Plan 1B.

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 $100 to $10,000 in $100 increments.

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 Will Benefits Begin?

The choice is yours ... benefits can begin after 30, 60 (Not available for Plan 1B), 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 Would You Need?

No two families are alike. That's why this plan gives you the flexibility to choose a coverage amount that fits your lifestyle. You can select to receive anywhere from $100 to $10,000 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 any Other Income Benefits (including Worker's Compensation, Social Security, employer-sponsored salary continuation, group or franchise plans or retirement programs) may not exceed 70% for Plan 1A and 50% for Plan 1B 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 ... 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).

Plan II ... 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.

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 30 days, performing the full-time duties of your occupation.

Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford. 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

The Hartford[1] approaches Managed Disability by placing emphasis on abilities rather than disabilities and empowering people with disabilities to help them 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.

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Rehabilitative Employment Benefit

If you participate in an approved vocational rehabilitation program within 31 days of receiving benefits, you will receive monthly benefits for up to 60 months while Totally Disabled. You will receive your regular monthly benefit less 50% of any income earned as a participant in the rehabilitation program. 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.

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 substantial and material duties of your own occupation on a full-time or part-time basis, you are not receiving Total Disability, and you are under the regular care of a physician. Partial Disability benefits will be paid up to your maximum benefit period and prior to age 70. If the Partial Disability lasts for part of a month, you will receive a portion (1/30th) of your chosen monthly benefit for each day of Partial Disability.

Benefits for Mental & Nervous Disorders, Alcoholism & Drug Addictions *(Plan I Only)*

Benefits will be paid for Total Disability due to Mental or Nervous Disorders, alcoholism, or drug abuse and 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 under Plan I, and only if you are an inpatient in a hospital or institution and under a doctor's care.

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 special 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 60 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 – 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.

Pre-Existing Conditions Limitation

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 12 months.

Successive Disabilities Limitation

Repeat disability claims due to different causes will be treated as separate disabilities, with a new Waiting Period and full benefit period. Successive Disabilities 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, 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.

Termination of 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 you remain a member 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.

Plan I

Plan 1A

Semi Annual Rates per $100 Monthly Benefit				
	30 Day EP	60 Day EP	90 Day EP	180 Day EP
Under age 30	$ 5.48	$ 4.11	$ 2.09	$ 1.88
30-34	$ 6.87	$ 5.15	$ 2.52	$ 2.27
35-39	$ 9.63	$ 7.23	$ 3.59	$ 3.23
40-44	$14.25	$10.69	$ 5.83	$ 5.25
45-49	$20.86	$15.64	$ 9.89	$ 8.90
50-54	$30.33	$22.75	$15.99	$14.39
55-59	$31.78	$23.84	$18.78	$16.90
60-64	$25.33	$19.00	$14.71	$13.24
65-69*	$25.37	$19.02	$15.06	$13.55

Plan 1B

Semi Annual Rates per $100 Monthly Benefit			
	30 Day EP	90 Day EP	180 Day EP
Under age 30	$ 4.38	$ 1.67	$ 1.50
30-34	$ 5.50	$ 2.02	$ 1.81
35-39	$ 7.71	$ 2.88	$ 2.59
40-44	$11.40	$ 4.67	$ 4.20
45-49	$16.69	$ 7.91	$ 7.12
50-54	$24.27	$12.80	$11.52
55-59	$25.44	$15.03	$13.53
60-64	$20.27	$11.77	$10.59
65-69*	$20.30	$12.05	$10.85

Plan II

Semi Annual Rates per $100 Monthly Benefit				
	30 Day EP	60 Day EP	90 Day EP	180 Day EP
Under age 30	$ 3.42	$ 2.57	$ 1.12	$ 1.01
30-34	$ 3.73	$ 2.80	$ 1.16	$ 1.05
35-39	$ 4.67	$ 3.51	$ 1.49	$ 1.34
40-44	$ 6.25	$ 4.69	$ 2.21	$ 1.99
45-49	$ 8.75	$ 6.56	$ 3.68	$ 3.31
50-54	$12.91	$ 9.68	$ 6.29	$ 5.66
55-59	$16.59	$12.44	$ 9.36	$ 8.43
60-64	$23.93	$17.95	$14.58	$13.12
65-69*	$30.89	$23.17	$19.08	$17.17

*For renewal purposes only.

Premiums increase on the premium due date occurring on or next following the date you enter a 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.

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

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How to Apply?

1. Complete, date and sign the Application. If your Spouse 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. Make your premium check payable 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 Insurance Company
Simsbury, CT 06089

[1]The Hartford is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing complany Hartford Life 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 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 Policyholder Association and Society Group Insurance Trust. This program may vary and may not be available to residents of all states.

Form SRP-1311 A (HL) (5637)
Policy Number AGP-5637

DI648P-AGP5637P
7/15

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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