GROUP TERM LIFE INSURANCE APPLICATION

Hartford Life and Accident Insurance Company
Hartford, Connecticut 06155

Please Print. Use Dark Ink. Do Not Erase. Initial All Changes. For Office Use: h w

Association Name: Academy of Nutrition and Dietetics	Policy No. AGL-1947	Certificate No. (Leave Blank)	
Proposed Insured's Name (First, Middle Initial, Last)	❑ Male ❑ Female	Date of Birth:	Height: ____ft. ____in. Weight: ________lb.
Street City State Zip Code	Phone No. ( )	E-mail Address: ____________________	
Proposed Insured's Occupation			
Beneficiary — Print full name & relationship to you Name ____________________ Relationship ____________________			
The Proposed Insured will be the beneficiary for any Dependent Coverage desired.			
Spouse's Name (First, Middle Initial, Last), if applying	❑ Male ❑ Female	Date of Birth:	Height: ____ft. ____in. Weight: ________lb.
Street City State Zip Code	Phone No. ( )	E-mail Address: ____________________	
Beneficiary — Print full name & relationship to you Name ____________________ Relationship ____________________			

Amount Desired: ($10,000 to $250,000 in multiples of $10,000)

Please indicate if request is for: ❑ New Coverage

Member: $________________

Spouse: $________________

❑ Change in Coverage

Member's Current benefit amount: $________________ Additional benefit requested: $________________ Total benefit: $______________

Spouse's Current benefit amount: $________________ Additional benefit requested: $________________ Total benefit: $______________

Child(ren) Coverage ❑ Yes ❑ No

If Dependent Coverage is desired, complete the following:

Full Name	Relationship	Birth Date	Height	Weight

	Member	Spouse
PLEASE COMPLETE THE FOLLOWING:	YES/NO	YES/NO
1. In the last 2 years, have you or your Spouse been unable to perform the full-time duties of your occupation for 10 consecutive days, or if not employed, been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90 day period immediately preceding the date of this application for 10 consecutive days?	❑ ❑	❑ ❑
2. 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 any disease or disorder of the digestive, urinary or reproductive systems?	❑ ❑	❑ ❑
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?	❑ ❑	❑ ❑
3. 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 have you been confined or treated in any hospital, sanatorium or similar institution?	❑ ❑	❑ ❑

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

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

(Attach sheet of paper if additional space is needed.) Please read carefully all items and sign below.

Form SRP-1153 AP (D) (HLA)

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

I hereby certify that I have read all statements and answers in this application, and in any other application or medical form required by the 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 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 paid my 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 or my dependent's physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status. Hartford Life and Accident Insurance Company will use the above information to decide if and to what extent I or my dependents are eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to the Hartford Life and Accident Insurance Company.

I authorize the Hartford Life and Accident Insurance Company to give information about me or my dependents to any other insurance company to whom I or my dependents may apply for Life and Health Insurance, the Medical Information Bureau, Inc., 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 my dependent's 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.

Member's signature (Sign name in full) ________________________________ Date ________________________

Spouse's signature (if applying) ____________________________________ Date ________________________

Please check "Yes" or "No" on the next line.
By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance?
Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

STATE NOTICE

Any person who includes any false or misleading information on an application or filing a claim for an insurance policy is subject to criminal and civil penalties. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, penalties may include imprisonment, fines, denial of insurance, and civil damages.

Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If while in the state of Florida, a person knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, the person is guilty of a felony in the third degree. Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false, misleading or deceptive information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to substantial civil and/or criminal penalty where and to the extent allowed by state law.

Life Form Series includes, GBD-1000, GBD-1100, or state equivalent.

Form SRP-1153 AP (D) (HLA)

LI648E-1947
4/19

Indicate how you wish to be billed:
☐ Automatic Monthly Check Withdrawal
☐ Semi-Annual Direct Bill
(If you select Automatic Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

TO APPLY:
Send this completed form to:
ACADEMY GROUP INSURANCE PROGRAM
P.O. BOX 10374
Des Moines, IA 50306-8812

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

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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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Group Term Life Insurance Plan

Academy of Nutrition and Dietetics

For Members of the Academy of Nutrition and Dietetics

This Plan offers...

Up to $250,000[1] for Members and Spouses

Up to $2,500 for Each Child ...of affordable INSURANCE protection!

Why Buy Life Insurance?

Throughout your life you've assumed many responsibilities and financial commitments. Life insurance can help you keep the promises you made. The proceeds of life insurance policy may be needed to help...

- Pay off a mortgage or continue rent payments.
- Provide an education fund for your children.
- Pay off business debts or other financial obligations.
- Pay taxes on your estate.
- Pay large medical bills due to a prolonged illness.
- Provide money for any other financial needs your survivors may face.

Why Should You Buy Life Insurance Now?

The time to buy life insurance is when you are in good health—tomorrow may be too late. Each year many applicants are declined outright by life insurance companies because of health or physical impairments. These people waited too long! Can you afford to risk your family's financial security? You won't regret having life insurance—only not having enough of it.

The Group Term Life Insurance Plan is designed to help provide you and your family sound financial protection at reasonable group rates.

As a member, you and your family have the opportunity to apply for up to $250,000 of life insurance protection in $10,000 units for yourself and your spouse. And up to $2,500 for each of your eligible children.

Take a positive step toward helping to secure your family's financial future and review the Group Term Life Insurance Plan today! Then complete the Application and return it. Remember, the time to buy life insurance is while you are healthy.

Who May Apply?

All active members of the Academy and Nutrition and Dietetics or a legally married Spouse of a member who are under age 60 and a resident of the United States.

Eligibility Restriction:

When Spouses are both Eligible Members:

1) coverage may not be duplicated by applying as dependents of each other; and

2) coverage for an Eligible Dependent Child may be requested by either Spouse, but not both. No Eligible Child will be covered unless either the Eligible Member or the Eligible Spouse is covered.

This coverage is available only for residents of the United States excluding ID, LA, NH, OR, TX, UT, WA.

IMPORTANT FEATURES OF THIS PLAN...

Budget Group Cost

Your premiums are kept at a minimum through the collective group buying power of your association's membership acting as a group and through the economies of centralized administration.

Waiver of Premium for Total Disability

If you are Disabled before you reach age 60 and remain disabled for at least six consecutive months, your insurance will remain in force without further premium payment as long as you are Disabled or until age 80. When your disability ends, premium payments resume.

Disabled means you are wholly and continuously prevented from performing any work for which you reasonably qualified or trained, or if not employed, from engaging in the normal or customary activities of a person of like age and gender in good health.

Your Choice of Beneficiary

You may name anyone as your beneficiary. You may change your beneficiary at any time by writing to the Insurance Administrator. Immediately upon proof of death, your beneficiary receives the benefit in a lump sum, monthly installments or a combination of both-whichever the beneficiary wishes. If you do not name a beneficiary the insurance amount will be paid to your survivors, in equal shares, to first your spouse; children; parents; brothers and sisters or to your estate.

Exclusion

This insurance is not payable in the event of death caused by suicide for the first two years of coverage or following the two years after an increase in coverage. During the first two years of coverage under the Policy an amount equal to the premium paid for coverage to the date of death will be paid. Following an increase in coverage, the benefit payable will be the amount of insurance in force before the increase plus premium paid for two years.

No Individual Cancellations

Your insurance cannot be cancelled as long as you pay your premium…are under age 80…and remain a member and the Master Policy is in force. Your dependent's coverage will remain in effect as long as your coverage is active, premiums are paid, and they meet the eligibility requirements.

Eligible Child or Children means your unmarried child, stepchild or legally adopted child who is primarily dependent upon you for support and maintenance and is at least 15 days old but under age 26 subject to the Incapacitated Child Continuation Provision.

Effective Date: Your coverage will become effective upon receipt and approval of your application, and payment of your first premium.

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.

Each child between the ages of 6 months and 26 years may be insured for $2,500 for the monthly premium rate of $1.08. That same rate will also insure each child age 14 days to 6 months for $500.

YOUR MONTHLY COST

MEMBER OR SPOUSE PER $10,000 OF COVERAGE

Age	Female	Male
Under 30	$ .60	$1.20
30–34	.90	1.20
35–39	1.20	1.90
40–44	2.20	2.50
45–49	3.10	4.90
50–54	3.90	5.70
55–59	5.50	9.00
60–64*	10.80	16.50
65–69*	7.02	13.71
70–79*	17.25	28.67

All premiums are based on the applicant's age at the date of issue and on attained age at renewal dates. Rates and/or benefits may be changed on a class basis.

*Shown for renewal purposes only—those under age 60 may apply.

[1]NOTE: Benefits reduce to 50% at age 65 and an additional 50% at age 75, and terminate at age 80. Rates shown reflect age-reduced benefits.

TO COMPUTE YOUR PREMIUM—multiply the cost for your age group by the number of units you desire (up to a maximum of 25 units or $250,000). For dependent coverage add $1.08 to cover all your children. To pay semi-annually, multiply your 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.

Administered by:

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

Questions?
1-800-503-9230
www.academymemberinsurancesite.com

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

Underwritten by:

Hartford Life and Accident Insurance Company
Hartford, CT 06155

*The Hartford® is The Hartford Financial Services Group, Inc., and its 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 AGL-1947 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 Trustees of the Qualified Association and Organization Trust.

LI648P-1947

Life Form Series includes GBD-1000, GBD-1100, 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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