APPLICATION FOR GROUP DISABILITY INCOME INSURANCE

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: American Dental Hygienists' Association		Policy No.: AGP-5879	Certificate No.: (Leave Blank)
Member's Name: (First, Middle Initial, Last)		❑ Male ❑ Female	Height: __ft. __in. Weight: ____lb.
Address: Street:			
City:		State:	Zip Code:
Phone Number (Daytime): ( )	Date of Birth:	Age Last Birthday:	Place of Birth (City/State/Country):
Occupation:		Business Telephone: ( )	
Duties:		Pre-Disability Earnings: $_____	
Business Address: Street:			
City:		State:	Zip Code:

IF SPOUSE/DOMESTIC PARTNER COVERAGE IS DESIRED, PLEASE COMPLETE THE FOLLOWING:

Spouse/Domestic Partner's Name: (First, Middle Initial, Last)		❑ Male ❑ Female	Height: __ft. __in. Weight: ____lb.
Address: Street:			
City:		State:	Zip Code:
Phone Number (Daytime): ( )	Date of Birth:	Age Last Birthday:	Place of Birth (City/State/Country):
Occupation:		Business Telephone: ( )	
Duties:		Pre-Disability Earnings: $_____	
Business Address: Street:			
City:		State:	Zip Code:

Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 20 hours per week) 90 days before the date of this application? You: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

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	Elimination Period	To be replaced? Yes	No

COVERAGE REQUESTED: ❑ New Coverage ❑ Change in Coverage		
Monthly Benefit Amount: Member $_____ Spouse/Domestic Partner $_____	Payment Period Option: ❑ Plan II	Elimination Period Option: Plan II ❑ 60 days ❑ 90 days ❑ 180 days
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		

	PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS BELOW:	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, liver, kidney disease, 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?	❑ ❑	❑ ❑
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?_____		
	Are there any medical complications?	❑ ❑	❑ ❑

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.)

Form SRP-1311 AP (A) (HLA)

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 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 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; consumer reporting agency; 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.

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 the Hartford Life and Accident Insurance Company.

I authorize the 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 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 two (2) years 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.

Signature of Member_____ Date _____

Signature of Spouse/Domestic Partner_____ Date _____

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.

I wish to pay my premiums:

- ❑ Automatic Monthly Check Withdrawal
- ❑ Semi-Annual Direct Bill

(If you select Automatic Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

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:

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

QUESTIONS?

1-800-503-9230
customerservice.service@mercer.com

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

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

DI648E-AGP5879EII
Policy Number AGP-5879
8/20

Form SRP-1311 AP (A) (HLA)

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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Group Disability Income Insurance Plan II

DEVELOPED FOR YOUR ASSOCIATION

There are two plans available for ADHA members. This brochure contains information specific to Plan II. Please review the Plan I application and brochure for information specific to Plan I.

THIS PLAN HELPS PROVIDE AN INCOME WHEN YOU CAN'T WORK

If a covered disabling sickness or injury suddenly took away your ability to work and as a result also took away your ability to earn a paycheck . . . how would you continue to afford the living expenses you must now pay? With the Group Disability Income Plan sponsored by your association, a portion of your income would continue in the form of a monthly benefit that you select. Don't let a disability rob you of your income. Rely on the protection provided by the Group Disability Income Plan.

WHO CAN APPLY

All Actively-at-Work (at least 20 hours per week) members and spouses/domestic partners not legally separated or divorced from the member, under age 60 may apply for this coverage. Member must apply for Spouse to apply. Member and spouse may not duplicate coverage by applying as dependents of each other.

This coverage is available only for residents of the United States excluding AK, ME, MD, MN, MO, NH, NM, NC, UT, WA.

HOW THIS PLAN WORKS - PLAN II

PLAN II pays up to age 65 if you are Totally Disabled due to a covered Injury or Sickness. Under Plan II, you have a choice of a 60, 90 or 180-day Elimination Period for benefits to begin. If Total Disability occurs at or after age 63, benefits are paid to a maximum of 2 years.

YOU CAN SELECT FROM $400 TO $6,000 IN MONTHLY BENEFITS

You select the monthly benefit you wish to receive ranging from $400 to $6,000 per month (in $100 increments). Your Monthly Benefit should not exceed 60% of your Pre-Disability Earnings. The actual monthly benefit amount at claim will be the lesser of: a) the benefit amount you selected, or b) 60% of your Pre-Disability Earnings less any Other Income Benefits you may receive and all other income from any employer or for any work.

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 Pre-Disability Earnings	$3,000.00
Disability benefits percentage	x 60%
Unreduced maximum benefit	$1,800.00
Less any Social Security disability benefit per month	-$900.00
Less any State Disability benefit per month	-$300.00
Total amount of disability benefit per month	$600.00

IMPORTANT PLAN FEATURES

Managed Disability Approach

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.

Successive and Recurrent Disabilities Limitation

The insured member will receive their selected benefit for disabilities, which are recurrent in nature. Recurrent periods of the same or related disabilities are payable as new benefit periods (eligible for new maximum durations) when separated by six consecutive months of full-time active employment. Periods of disability, if due to the same or related medical causes and separated by fewer than six months while you are Actively-at-Work, are considered a single period of Successive disability. Periods of disability from entirely unrelated causes are considered separate periods of disability.

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

EFFECTIVE DATE

Your and your Spouse's insurance will become effective on the first of the month on or next following the date of approval of your and your Spouse's application, provided the required premiums are paid. However, your Spouse's coverage will not become effective prior to the date your coverage becomes effective. 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.

CONVENIENT PAYMENT OPTIONS

You are able to choose between two premium payment options, whichever one best suits your needs:

Option 1: Automatic Monthly Check Withdrawal. Your premium will be automatically deducted from your checking account on a monthly basis. This not only saves you time, but you don't have to worry about missing a payment.

Option 2: Semi-Annual Direct Bill.

SATISFACTION GUARANTEED

When you receive your Certificate of Insurance, review it carefully. If you are not completely satisfied with the terms of your coverage, simply return your Certificate within 30 days and any premiums that have been paid will be promptly refunded in full, minus any claims paid.

IMPORTANT DEFINITIONS

Total Disability

You or your spouse are considered totally disabled if you or your spouse have a disability during the Elimination Period and the following 24 months that prevents you or your spouse from performing the essential duties of your or your spouse's occupation. Thereafter, you or your spouse are totally disabled if you or your spouse are continuously unable to engage in any occupation for which you or your spouse are qualified by education, training or experience.

However, if you or your spouse are Totally Disabled due to Mental Illness, alcoholism or Substance Use Disorder, the Maximum Payment Period will be reduced to 2 years during your or your spouse's lifetime unless you or your spouse are confined in a hospital or other institution licensed to provide care and treatment for that disability.

Disabled and Working Benefit

You or your spouse may receive a Disabled and Working benefit equal to 50% of your Current Monthly Earnings. The Disability must begin before you or your spouse attain age 70 while you are covered under this plan. Benefits will continue until your/your Spouse's Disabled and Working benefit exceed 80% of your Pre-Disability Earnings, until you/your Spouse are eligible to receive the Total Disability Benefit due to the same or related causes or the date you or your spouse return to work in an occupation other than your own.

Pre-Disability Earnings

- If you are self-employed, your average net monthly income after business expenses for 12 months or 24 months, whichever produces the higher average, or
- If you are not self-employed, your regular monthly pay (not commissions, bonuses, tips and tokens, overtime pay or other fringe benefits/extra compensation) immediately prior to the Total Disability.

Other Income Benefits

The actual benefit you receive at the time of your claim may be different, depending upon your income, offsets for Other Income Benefits and other variables. Other Income Benefits means the amount of any benefit for loss of income that you or your family receive or are eligible to receive from Social Security Disability Income or similar plans; Worker's Compensation or occupational disease laws or similar laws; group, association, union or other organizational coverage; employer-related individual policies; governmental laws or programs that provide disability or unemployment benefits as a result of your job with any employer; disability coverage under any employer's retirement plan; damages or settlements for income loss; and no-fault automobile insurance plans.

Other Income Benefits also include retirement benefits from retirement plans that are wholly or partially funded by employer contributions, unless you were receiving them prior to becoming disabled or you immediately transfer the payments to another plan qualified by the U.S. Internal Revenue Service for the funding of a future retirement. Finally, Other Income Benefits include retirement benefits you or your family receives from Social Security or similar plans, unless you were receiving them prior to becoming disabled.

TERMS OF COVERAGE

Exclusions and Limitations

This Policy does not cover any Disability or loss caused by: intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane; pregnancy or childbirth except for Complications of Pregnancy; war or act of war, whether declared or not; any Injury sustained while riding on, boarding, or alighting from, any aircraft: as a pilot, crew member or student pilot; 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 being used for tests, experimental purposes, stunt flying, racing or endurance tests; your commission or attempted commission of a felony; or 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.

We will refund the pro rata portion of any premium paid for you while you are in the armed forces on full-time active duty for a period of two months or more. Written notice must be given to us within 12 months of the date you enter the armed forces.

Pre-Existing Conditions Limitation

During the first 24 months of coverage, losses incurred for Pre-Existing Conditions are not covered unless you have been free of medical care for that condition for 12 months ending on or after your coverage effective date.

Pre-Existing Condition means any Disability 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 Elimination Period is over.

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 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.

Waiver of Premium

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

MONTHLY PREMIUMS PER $100 MONTHLY BENEFIT PLAN II			
AGE	ELIMINATION PERIOD		
	60 days	**90 days**	**180 days**
Under 30	$0.95	$0.60	$0.40
30–34	1.25	0.85	0.55
35–39	1.70	1.15	0.80
40–44	2.65	1.80	1.36
45–49	4.10	2.80	2.26
50–54	5.75	4.00	3.20
55–59	7.50	5.20	4.15
60–64*	7.70	5.30	4.40
65–69*	7.80	5.40	4.96

Rates are based on the attained age of the insured person and increase as you enter each new age category. Rates and/or benefits in this brochure will not be changed unless they are changed for all insureds in your classification.

*For renewal purposes only—only those under age 60 may enroll.

TO COMPUTE YOUR PREMIUM: Multiply the premium listed for your age group by the number of $100 units of monthly coverage you select.

If you select the direct billing option and want to figure out your semi-annual premium, multiply the premium listed for your age group by 6. Then take that total and multiply by the number of $100 units of monthly coverage you select.

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.

The monthly benefit amount you select may not exceed 60% of your Pre-Disability Earnings. Please refer to the above section for more details.

How to Apply!

1. Complete, date and sign the enclosed Application. If your spouse is also applying, please complete the form and sign where indicated. If your domestic partner is applying, please complete and sign Domestic Partner Affidavit Form and return with your Application.
2. **Send no money now.** You will be billed when your application is approved and your Certificate is issued.
3. Mail your completed Application to:
   ADHA PROGRAM INSURANCE
   P.O. Box 10374
   Des Moines, IA 50306-8812

Program Offered by:

Association Member Benefits Advisors, LLC., which acts as the insurance broker for the Group Policyholder, is appointed by The Hartford, and is compensated for the placement of insurance.

In CA d/b/a Association Member Benefits & Insurance Agency

CA Insurance License #0I96562 | AR Insurance License #100114462

P.O. Box 10374
Des Moines, IA 50306-8812

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

Underwritten by:

Hartford Life and Accident Insurance Company
Hartford, CT 06155

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

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

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 the 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.

This program may vary and may not be available to residents of all states.

Policy Number AGP-5879

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

DI648P-5879IIP
8/20

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HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Notice of Information Practices

This notice applies to residents of: All states, excluding Massachusetts.

The Hartford Life and Accident Company respects your right to privacy and values your trust. This Notice explains how we collect, use and protect your personal information and your rights regarding that information.

Information We Collect: While your application for insurance is our primary source of information about you, we may also need to collect or verify information from other sources such as physicians and other medical and health care providers and professionals, health facilities such as hospitals, clinics, pharmacies, employers, consumer reporting agencies, and insurance-support organizations, which may provide us with an investigative consumer report about you. Organizations that provide us with consumer reports about you may disclose the contents of the report to others for which such organization performs such services. We may collect personal information about you that is necessary to determine your eligibility for insurance, to service your insurance policy, and otherwise as permitted by law; the information may include information from which judgments can be made about your age, health and medical history, occupation, avocations, finances, credit, character, habits, general reputation, or any other personal characteristics. We also collect information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment and claims history.

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 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 Model 400, Braintree, Massachusetts 02184-8734. 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.

Disclosure of Personal Information: We will not disclose your personal information to third parties without your authorization except in connection with our business or as otherwise permitted or required by law. For example, in connection with our general business practices, we may disclose personal information we collect to: companies performing services or functions on our behalf, including other insurers, agents or insurance support organizations, including for the purpose of determining your eligibility for insurance benefits or payments; detect or prevent fraud or criminal activity in connection with insurance transactions; medical care institutions or medical professionals for the purposes of verifying coverage or benefits; insurance regulatory authorities or law enforcement of other governmental authorities to prevent or prosecute the perpetration of fraud; the policyholder of a group insurance policy (for example an employer who provides group insurance) for purposes of reporting claims experience, conducting an audit of our operations or services, risk mitigation or other permissible purposes; third parties who collect data regarding claims for purposes of underwriting and claims handling, or to a third party as otherwise permitted or required by law; or reinsurers.

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

Form PA-10210 (2018)

How We Protect Your Information: We employ administrative, technical and physical safeguards to protect the security, confidentiality and integrity of personal information. We will continue to protect your information even when a business relationship no longer exists between us.

Right to Access and Right to Correct/Amend/Delete: You have the right to learn what personal, including medical, information we have in our files about you, to whom it has been recently disclosed, to have access to the information, to correct the information, and to receive a copy. We are not required to provide you access to information that is collected when we evaluate a claim or when the possibility of a lawsuit exists.

Please contact us if you would like access to your information from your files. There may be a reasonable charge for copies of records. If you think your file contains incorrect information, notify us indicating what you believe is incorrect and your reasons. We will investigate the matter and either correct our records or place a statement from you in our files explaining why you believe the information is incorrect. We will also notify persons or organizations to whom we previously disclosed the information of the change or your statement.

If you request access to medical record information that was supplied to us by a medical care institution or medical professional, we may choose to provide it to a medical professional designated by you.

Rights Relating to Adverse Underwriting Decision: You have the right to certain information relating to adverse underwriting decisions we may make about You, including the reason for such decision. In the event we make an adverse underwriting decision relating to You, we will provide You with information regarding such decision and Your rights.

How to make a request: If you wish to exercise your rights as provided in this notice, please provide us with your full name, complete address, your policy number or other identifying information and a reasonable description of the information you wish to access or correct. Please send your written request to: The Hartford, Attn: Medical Underwriting, PO Box 2999, Hartford, CT 06104-2999.

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

Form PA-10210 (2018)

This notice applies to residents of Massachusetts.

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 Model 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.
PA-9369