

For Members of the American Dental Hygienists' Association
DISABILITY INCOME INSURANCE APPLICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
 Hartford, Connecticut 06155



- TO APPLY:**
1. Complete and sign the application.
 2. Send no money with your application.
 You will be billed upon approval.
 3. Use the postage paid envelope provided to return to:
 ADHA GROUP INSURANCE PROGRAM
 P.O. Box 10374
 Des Moines, IA 50306-8812



Section 1

Association Name: American Dental Hygienists' Association	Policy No.: AGP-5879	Certificate No.: (Leave Blank)
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Section 2

Name: (First, Middle Initial, Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: ___ ft. ___ in. Weight: _____ lb.	
Street:		City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):		Place of Birth (State/Country):	Daytime Phone No.: ()	
Fax Number: ()	Email Address: _____			

Section 3

Spouse/Domestic Partner's Name: (First, Middle Initial, Last), if applying		<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: ___ ft. ___ in. Weight: _____ lb.	
Street:		City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):		Place of Birth (State/Country):	Daytime Phone No.: ()	
Fax Number: ()	Email Address: _____			

The Hartford® is Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company.

Section 4

COVERAGE REQUESTED:

Member Coverage:

New Coverage: Monthly Benefit Amount: \$ _____

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

Change in Elimination Period:
Plan 1 60 days

Spouse/Domestic Partner Coverage:

New Coverage: Monthly Benefit Amount: \$ _____

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

Change in Elimination Period:
Plan 1 60 days

Section 5

Is the Monthly Benefit Amount herein applied for equal to or less than 70% of your Pre-Disability Earnings?
You: Yes No Spouse/Domestic Partner: Yes No

Section 6

ALL QUESTIONS ARE ANSWERD TO THE BEST OF MY KNOWLEDGE AND BELIEF:

	Member		Spouse/ Domestic Partner	
	YES/NO	YES/NO	YES/NO	YES/NO
1. During the last 5 years, have you or your Spouse been diagnosed or been treated for cancer, tumor, high blood pressure, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any disease or disorder of the glands, any lung or respiratory disorder, liver, kidney or genitourinary disorder, alcohol or drug dependency, mental or nervous disorder, bone, joint, back, muscle or connective tissue disorder, or chronic fatigue syndrome?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you or your Spouse ever been diagnosed or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you or your Spouse been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 7

Please review your answer to these questions to be sure that you have answered them fully and truthfully. Answering "Yes" to any of these questions disqualifies you from acceptance for coverage at this time.

We understand that coverage will not become effective until the Company grants its underwriting approval and the administrator is in receipt of the first payment of premium. We do not receive temporary or conditional insurance coverage just because we submit an application.

By signing below, we acknowledge that we have read and agree to all terms on the reverse of this form.

Section 8

AUTHORIZATION

I hereby certify that I have read or have had read to me all statements and answers in this application, and in any other application or medical form required by Hartford Life and Accident Insurance Company, and that they are full, complete, and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk. I understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs. Subject to the deferred effective date provision, I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; Medical Information Bureau, Inc.; or employer; to give Hartford Life and Accident Insurance Company or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage. Hartford Life and Accident Insurance Company will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to Hartford Life and Accident Insurance Company.

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I authorize Hartford Life and Accident Insurance Company to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I may apply for Life or Health Insurance, or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application or as required by law. I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my coverage or, if no coverage has been issued one (1) year from the date of this application.

I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request. I certify that I have received the Notice of Insurance Information Practices. I agree that this document and all of its contents shall form a part of my enrollment request for group benefits.

PRE-EXISTING CONDITIONS LIMITATION: I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until 24 months after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation. I further understand that any condition excluded or limited by the policy or by a Health Waiver attached to my certificate will not be covered under this policy at any time.

Notice: I understand that California law prohibits an HIV test from being required or used by Health Insurance Companies as a condition of obtaining health insurance coverage.

Section 9

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

Section 10

Member's signature (Sign name in full) _____ Date _____
Required Required

Spouse/Domestic Partner's signature (if applying) _____ Date _____
Required Required

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

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

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

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

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:** _____