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.)

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.)

American Dental Hygienists' Association

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

Mercer

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC

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

Form SRP-1311 AP (A) (HLA)

DI648E-AGP5879EII
Policy Number AGP-5879
8/20