



# GROUP DISABILITY INCOME INSURANCE PERSONAL HEALTH APPLICATION

Hartford Life and Accident Insurance Company  
One Hartford Plaza Hartford, Connecticut 06155



**Association:** American Dental Hygienists' Association

**Administrator:** Mercer Health & Benefits Administration LLC  
P.O. Box 10374  
Des Moines, IA 50306-8812

**Questions?** Call toll-free: 1-800-503-9230  
Email: customerservice.service@mercerc.com

Please Print.	Use Dark Ink.	Do Not Erase.	Initial All Changes.	For Office Use.
Policyholder (and Participating Organization): <b>American Dental Hygienists' Association</b>			Policy No. AGP-5879	Certificate No. (Leave Blank)

Member's Name (First, Middle Initial, Last)				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth:	Place of Birth (State/Country):	Social Security Number:	Height ft. _____ in. _____	Weight: _____ lbs. (if currently pregnant, pre-pregnancy weight)	

Street _____  City _____ State _____ Zip Code _____	Preferred Phone No. _____  <input type="checkbox"/> Cell <input type="checkbox"/> Daytime <input type="checkbox"/> Home <input type="checkbox"/> Evening	Email: _____
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Member's Occupation _____	<input type="checkbox"/> I am a current ADHA member.  Member Number _____
Specialty/Duties _____	
Annual Salary \$ _____	

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

<b>Spouse/Domestic Partner's Name</b> (First, Middle Initial, Last) _____				<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth: _____	Place of Birth (State/Country): _____	Social Security Number: _____	Height ft. _____ in. _____	Weight: _____ lbs. (if currently pregnant, pre-pregnancy weight)

Street _____ City _____ State _____ Zip Code _____	Preferred Phone No. _____ <input type="checkbox"/> Cell <input type="checkbox"/> Daytime <input type="checkbox"/> Home <input type="checkbox"/> Evening	Email: _____
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Spouse/Domestic Partner's Occupation _____	Annual Salary \$ _____
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**COVERAGE REQUESTED:**

<b>DISABILITY INCOME</b>			
Member Coverage			
Monthly Benefit Amount: Member \$ _____	Payment Period Option: Plan II <input type="checkbox"/>	Elimination Period Option: Plan II <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days	
Spouse/Domestic Partner \$ _____	Payment Period Option: Plan II <input type="checkbox"/>	Elimination Period Option: Plan II <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days	

<p>Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Pre-Disability Earnings minus any Other Income Benefits?</p>	MEMBER	SPOUSE/ DOMESTIC PARTNER
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Do you consume alcohol? If "yes", please indicate:</p> <p>Amount:</p> <p>Member: per weekday: _____ per weekend: _____</p> <p>Spouse: per weekday: _____ per weekend: _____</p>	MEMBER	SPOUSE/ DOMESTIC PARTNER
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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PLEASE COMPLETE THE FOLLOWING:	MEMBER	SPOUSE/ DOMESTIC PARTNER
<p>1. Have you ever been diagnosed or treated for high blood pressure, tumor, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any disease or disorder of the glands, thyroid, any lung or respiratory disorder, liver, kidney or genitourinary disease or disorder, including hepatitis, alcohol or drug abuse or dependency, mental or nervous disorder, neurological impairment, bone, joint, back, muscle or connective tissue disorder, or Chronic Fatigue Syndrome?</p> <p>If "yes", indicate: Diagnosis by your physician: _____</p> <p>Date of diagnosis: _____</p> <p>Treatment including medication, dosage, date last taken: _____</p> <p>Has the medical professional treating you for this condition released you from care?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. In the past 10 years have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC*) or any other Disorder of the Immune System as defined below?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Have you ever been confined in a hospital, nursing home, sanatorium or similar institution (excluding maternity)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Have you ever been diagnosed or treated by a member of the medical profession for cancer?</p> <p>If "yes", indicate: Type of cancer diagnosed by your physician: _____ Date treatment completed: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Have you ever been diagnosed or treated by a member of the medical profession for seizures?</p> <p>If "yes", indicate: Type of seizure diagnosed by your physician: _____</p> <p>Date of diagnosis/onset: _____</p> <p>Cause of seizures: _____</p> <p>Frequency of seizures: _____</p> <p>Date of last seizure: _____</p> <p>Medication, dosage, date last taken: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>6. In the past 5 years have you consulted any medical professional, surgeon, psychologist, psychiatrist or other practitioner, other than yourself if you are a physician, or a family member, for any reason not previously noted on this application?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7. Have you been advised to have a medical test done or are you awaiting treatment for a medical condition?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>8. Are you currently pregnant?</p> <p>Are there any medical complications? _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to any of the above questions, provide the details below to include the condition, diagnosis, number of episodes, duration, severity, date of last symptom, current status, treatment, medications and dosages, test results, any further treatments planned and the medical professional's and hospital's name, address and phone number. If additional space is needed, provide additional sheet with details.

Question Number, Condition, Dates and Details	Name of Family Member	Medical professional's name, full address and phone number

**AIDS Related Complex (ARC)\*** is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

Please read all items carefully and sign below.

**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION**

**Notice**

To the best of your knowledge, you are required to notify Hartford Life and Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date coverage is approved.

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, and copies of medical records which you have authorized us to review, and information obtained from MIB, Inc.

**Authorization**

I, an undersigned applicant, authorize Hartford Life and Accident Insurance Company, together with its affiliates, ("Company") to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

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In the event that I cannot be reached via telephone, I authorize a representative of the Company to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that he or she is calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company by telephone.

Yes, you may leave a message as indicated above.  No, please do not leave a message.  
(If not checked, you will not be contacted by phone.)

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize any employer, any health or benefits plan, physician, counselor, medical professional, hospital, clinic or medical facility, laboratory, MIB, Inc., pharmacy or pharmacy benefits manager, motor vehicle violation reporting agency, consumer reporting agency that possesses my protected Personal Health Information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), drug and alcohol use history, other insurance coverage or employment status to furnish such protected health information to the Company or its representative. If the Company requests an investigative consumer report, I acknowledge that I may be interviewed in connection with that report. I understand that, upon my written request to the Company, I may receive a copy of the report. The Company may only use information disclosed under this Authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

I acknowledge that I am currently a member of the Association and understand I must retain membership to be eligible for this insurance plan. I hereby acknowledge 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 any deferred effective date provision, I understand that coverage will not become effective until (a) the Company grants its underwriting approval; and b) at the time of payment of the first premium, I am living, and my insurability remains the same as that described in the application. I do not receive temporary or conditional insurance coverage just because I submit an application and paid my first premium.

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 MIB, 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.

**PREMIUM PAYMENT**

I wish to pay my premiums:  Monthly  Quarterly  Semi-annually  Annually

Automatic Bank Withdrawal (Electronic Funds Transfer):

Name: \_\_\_\_\_ Banking Institution: \_\_\_\_\_

Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

Bank Account Type: \_\_\_\_\_ Checking \_\_\_\_\_ Savings

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I authorize the Administrator to initiate my regular payment from the bank account provided above. I understand that payment will be processed on or after the due date and will continue to be charged or deducted from my account unless I notify the Administrator otherwise in writing or my coverage ends. I also understand if corrections of the debit are necessary, this may involve an adjustment to my account.

**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 1 year period prior to my/our effective date of coverage will not be covered until I/we have gone 1 year ending on or after my/our effective date of coverage without medical advice or treatment for that condition, or until 2 years 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.

**Member's signature** (Sign name in full) \_\_\_\_\_ Date \_\_\_\_\_  
Required Required

**Spouse/Domestic Partner's signature** \_\_\_\_\_ Date \_\_\_\_\_  
(if applying) Required Required

**For residents of Oregon:** 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 that the insurer relied upon is subject to a denial of insurance benefits and may be subject to any civil penalties available.



**Mercer Health & Benefits Administration LLC**

**Return Completed Form Today to:**  
ADHA GROUP INSURANCE PROGRAM  
P.O. Box 10374  
Des Moines, IA 50306-8812

**QUESTIONS?**  
**1-800-503-9230**  
**customerservice.service@mercer.com**