Office of the Administrator
P.O. Box 14464
Des Moines, IA 50306-8993

ENDORSED BY: Air Force Sergeants Association
RE: AFSA SIMPLIFIED ISSUE TERM LIFE INSURANCE PLAN BENEFIT

Dear AFSA Member,

The Air Force Sergeants Association (AFSA) has approved the release of this official notification to inform you about its member benefit.

To apply for coverage, you must complete, detach and return the Application Form attached below for approval.

With your member benefit—the AFSA Simplified Issue Term Life Insurance Plan—you can easily apply for up to $200,000.00 in valuable term life coverage.

No long, complicated form to fill out.

Under this Plan, you would also collect an additional $1,000.00 in lump sum cash benefits if you have a Heart Attack, Stroke or are diagnosed with Cancer. This is valuable coverage specifically designed to help give you some additional money to use any way you want—to pay extra medical expenses, household bills or other expenses—it's your choice.

As an AFSA member, you qualify for economical group rates which are not available to the general public.

Note: Your rates are this economical because when AFSA went to the bargaining table, they were armed with the full buying clout of nearly 115,000 members.

In addition, your spouse can easily apply for this desirable Life Plan, too. However, you the member must have coverage for spouse to apply. (Also, spouse coverage cannot exceed member coverage.)

You should give careful consideration to applying for coverage for you and your spouse for more family protection. Here's why:

AFSA doesn't want you or your loved ones to suffer financially if something were to happen and there wasn't enough life insurance protection. So, they negotiated a Plan that is easy to apply for and very economical.

The result: The AFSA Simplified Issue Term Life Insurance Plan. This Plan meets all of the demanding criteria set forth by AFSA. Therefore, it carries the full endorsement of AFSA.

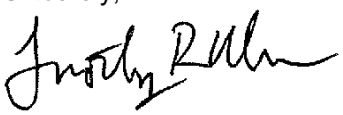
To apply for your AFSA Life Plan coverage:

1. Complete the Benefit Application Form that is enclosed with this letter.
2. Mail today.
3. SEND NO MONEY NOW.

Once your application is received and approved, we'll issue a Certificate of Insurance you can review for 30 days. If the Plan is right for you, then pay the accompanying bill. If not, do nothing. You're under no obligation.

The opportunity you have today is one of the many benefits that comes from your membership in AFSA. If you are interested, please return your Benefit Application Form today.

Sincerely,



Timothy R. Weber, Partner
Mercer Health & Benefits Administration LLC
AFSA Insurance Plans Administrator
License #17526255

P.S. Now, you can easily obtain up to $200,000.00 in economical term life coverage and an additional $1,000.00 additional cash benefit if diagnosed with a Critical Illness—thanks to the AFSA Simplified Issue Term Life Insurance Plan. To activate your coverage, complete and return the Application attached.

Please read the enclosed materials for more information including costs, exclusions, limitations and terms of coverage.

Life Form Series includes SRP-1153, or state equivalent.

For Members of the Air Force Sergeants Association

GROUP TERM LIFE INSURANCE APPLICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Hartford, Connecticut 06155

THE HARTFORD

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:

AFSA GROUP INSURANCE PROGRAM
P.O. Box 14464
Des Moines, IA 50306-8993

E-Mail: afsa.service@mercer.com

01477
074030010144

SECTION 1

Association Name: Air Force Sergeants Association	Policy No.: AGL-1725	Certificate No.: (Leave Blank)

SECTION 2

Proposed Insured Name: (First, Middle Initial, Last)	❑ Male ❑ Female	Date of Birth (MM/DD/YYYY):
Height:_____ft._____in. Weight:_____lb.	Place of Birth (State/Country):	
Street: City: State: Zip Code:		Phone No.( )
Beneficiary - Print full Name & relationship to you Name:_____ Relationship:_____		

SECTION 3

Spouse's Name (First, Middle Initial, Last), if applying	❑ Male ❑ Female	Date of Birth (MM/DD/YYYY):
Height:_____ft._____in. Weight:_____lb.	Place of Birth (State/Country):	

SECTION 4

Please select:

Member: ❑ $25,000 (_0H1) ❑ $50,000 (_0N1) ❑ $75,000 (_0T1) ❑ $100,000 (_0Y1) ❑ $125,000 (_YH1) ❑ $150,000 (_YN1) ❑ $175,000 (_YT1) ❑ $200,000 (_0Z1)

Spouse: ❑ $25,000 (_0H5) ❑ $50,000 (_0N5) ❑ $75,000 (_0T5) ❑ $100,000 (_0Y5) ❑ $125,000 (_YH5) ❑ $150,000 (_YN5) ❑ $175,000 (_YT5) ❑ $200,000 (_0Z5)

SECTION 5

At any time during the past 12 months to the present, has anyone proposed for coverage smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff? Member ❑ Yes ❑ No Spouse ❑ Yes ❑ No

SECTION 6

All questions are answered to the best of my knowledge and belief:		Member YES/NO	Spouse YES/NO
1.	During the last 5 years, have you or your Spouse been diagnosed with or been treated for a heart condition, diabetes, kidney or liver disorder, lung or respiratory disease, neurological impairment, blood or circulatory disorder (including high blood pressure but excluding HIV), alcohol or drug abuse, cancer, or enlarged lymph glands?.....	❑ ❑	❑ ❑
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?.....	❑ ❑	❑ ❑
3.	Have you or your Spouse been confined in a hospital, nursing home, sanatorium or similar institution in the last 6 months (excluding maternity)?.....	❑ ❑	❑ ❑

SECTION 7

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

I/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. I/We do not receive temporary or conditional insurance coverage just because I/we submit an application. By signing this application, I/we acknowledge that the application is true and accurate for each person to be insured.

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

SECTION 8

Please read carefully all items and sign below.

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 Hartford, 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 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 The Hartford 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 except drug and alcohol treatment information.

The Hartford 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.

I authorize The Hartford to give information about me to any other insurance company to whom I or my dependent 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 or authorized by law.

SECTION 8 ***(continued)***

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. I agree that this document and all of its contents shall form a part of my enrollment request for group benefits.

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

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

Spouse's signature (if applying)_____ Date_____
Required Required

SECTION 10

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?

You: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

SEND NO MONEY NOW!

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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.

PA-9369

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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.

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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OUTLINE OF AFSA BENEFITS

The following outline of the AFSA Simplified Issue Term Life Insurance Plan benefits is posted for AFSA members and their spouses:

1. Available to AFSA members and spouses only.

The AFSA Life Plan was designed for AFSA members and their spouses under age 65 who reside in the U.S., and who are not Confined for medical care or treatment in an institution or at home—it is not available to the general public.

2. Provides up to $200,000.00 in Term Life protection.

With this Plan, you can select the benefit amount you want from $25,000.00 to $200,000.00, making it ideal to either:

- Add to your existing coverage

  OR
- Start a life insurance plan for your loved ones.

3. Pays a $1,000.00 cash benefit for Critical Illness.

If you are under age 65, have at least $25,000 in coverage and have a Heart Attack, Stroke or are diagnosed with Cancer, you will collect a $1,000.00 lump sum cash benefit to use any way you want—to help pay extra medical expenses or household bills—the choice is yours!

4. Easy to Apply.

Simply complete and return the Benefit Application Form for approval.

This coverage is available only for residents of the United States excluding ID, ME, MN, MT, NM, NY, OR, SC, SD, VT and WA.

5. Waives your premium if Totally Disabled.

If a Sickness or Injury makes you Totally Disabled for at least nine consecutive months and your Total Disability starts before you're age 60, your benefits will continue at no cost to you. Your premium will be taken care of for as long as you're Totally Disabled up to age 85.

6. Economical group rates.

Thanks to the group purchasing power of 115,000 AFSA members, your rates are economical. See for yourself:

Simplified Issue Plan Monthly Group Rates

	$25,000		$50,000		$75,000		$100,000	
Age	**Smoker**	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Smoker**	**Non-Smoker**
19-34	$3.67	$2.00	$7.34	$4.00	$11.01	$6.00	$14.68	$8.00
35-39	$5.25	$2.79	$10.50	$5.58	$15.75	$8.37	$21.00	$11.16
40-44	$8.21	$4.30	$16.42	$8.60	$24.63	$12.90	$32.84	$17.20
45-49	$13.25	$6.84	$26.50	$13.68	$39.75	$20.52	$53.00	$27.36
50-54	$23.58	$12.16	$47.16	$24.32	$70.74	$36.48	$94.32	$48.64
55-59	$40.66	$20.66	$81.32	$41.32	$121.98	$61.98	$162.64	$82.64
60-64	$55.71	$28.59	$111.42	$57.18	$167.13	$85.77	$222.84	$114.36
65-69*	$82.50	$41.08	$165.00	$82.16	$247.50	$123.24	$330.00	$164.32
70-84**	$107.96	$53.79	$215.92	$107.58	$323.88	$161.37	$431.84	$215.16

	$125,000		$150,000		$175,000		$200,000		$10,000
Age	**Smoker**	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Child**
19-34	$18.35	$10.00	$22.02	$12.00	$25.69	$14.00	$29.36	$16.00	$1.25
35-39	$26.25	$13.95	$31.50	$16.74	$36.75	$19.53	$42.00	$22.32	
40-44	$41.05	$21.50	$49.26	$25.80	$57.47	$30.10	$65.68	$34.40	
45-49	$66.25	$34.20	$79.50	$41.04	$92.75	$47.88	$106.00	$54.72	
50-54	$117.90	$60.80	$141.48	$72.96	$165.06	$85.12	$188.64	$97.28	
55-59	$203.30	$103.30	$243.96	$123.96	$284.62	$144.62	$325.28	$165.28	
60-64	$278.55	$142.95	$334.26	$171.54	$389.97	$200.13	$445.68	$228.72	
65-69*	$412.50	$205.40	$495.00	$246.48	$577.50	$287.56	$660.00	$328.64	

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.

Rates for members over 65 are for renewal only.

*No Critical Illness coverage offered for ages 65 and older.

** At age 70, coverage reduces to a maximum of $100,000.

(Next page, please)

You qualify for nonsmoker rates if you haven't smoked cigarettes, cigars, or used a pipe or chewing tobacco, nicotine chewing gum or snuff during the 12-months prior to the date you apply for coverage. For your convenience, you'll be billed every three months. Your individual premium is determined at each premium due date and is based on your benefit level, attained age and smoking status. Your rates are based on your attained age and increase as you enter each new age category. You can never be singled out for a rate increase or a change in benefits, and we will notify you in advance in writing of any changes. Rates and/or benefits may be changed on a class basis.

Effective Date: Your AFSA Life protection will start on the first day of the month after your coverage has been approved and your first premium has been paid. If on the date that you are to become covered under this Policy, you are confined for medical care or treatment at an institution or at home, coverage will not take effect until the date following your final medical discharge from such confinement.
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.

Termination of Coverage: You can keep your AFSA Life coverage up to age 85—no matter what your health—as long as you remain an AFSA member, pay your premiums on time and the Master Policy stays in force. Coverage for your spouse will continue for as long as your coverage remains in force and if they are no longer eligible due to age and marital status.

Exclusion for Term Life Benefit: The only thing that isn't covered is suicide during the first two years of coverage. Benefits paid for death caused by suicide while sane or insane within the first two years of the effective date of insurance are limited to a refund of the premiums paid for the insured's insurance. The two year suicide exclusion, stated above, will also apply if a Covered Person commits suicide during the two years immediately following an increase in coverage under the Policy. In that event, the amount of insurance payable will equal the amount of insurance in force prior to the increase plus an amount equal to the premium paid for the increase to the date of death.

Exclusions and Limitations Related to the Critical Illness Benefit: This benefit will not be payable during the Waiting Period; or if the covered person dies within the 30-day period immediately following a positive diagnosis of a Critical Illness; or if the covered person has already received a Critical Illness benefit; or for a Critical Illness that was positively diagnosed prior to the covered person's effective date of coverage under this Plan; or for any disease, sickness or injury, except as expressly stated; or for a Critical Illness that is diagnosed by the insured person or any member of his/her immediate family; or for a Critical Illness contracted as a result of war or act of war, or service in the armed forces of any country. Critically Ill or Critical Illness means Cancer, Heart Attack and Stroke, as defined.

- Cancer means the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes Hodgkin's disease, leukemia, lymphoma, carcinoma, sarcoma or malignant tumor. It does not include other conditions that may be considered precancerous, including, but not limited to: leukoplakia, actinic keratosis, carcinoid, hyperplasia, polycythemia, nonmalignant melanoma, moles, basal cell carcinoma, or similar diseases or lesions. Cancer does not mean carcinoma in situ.
- Heart Attack means a myocardial infarction only. Heart Attack does not include any other disease, arrhythmia or injury involving the cardiovascular system. Cardiac arrest not caused by myocardial infarction is not a Heart Attack.
- Stroke means a cerebrovascular accident that results in paralysis lasting more than 24 hours and produces measurable neurological deficit persisting for at least 30 days following the occurrence of the Stroke. Stroke does not mean a head injury, transient ischemic attack or chronic cerebrovascular insufficiency.

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.

100% SATISFACTION GUARANTEED

There's no obligation in taking a closer look at the FRA Term Life Insurance Plan today. You don't even send money now. Simply complete and mail your Benefit Application Form and we'll send you your official Certificate.

Take 30 days to look it over. When you're satisfied it's the right Plan for you, pay for it then. If it doesn't work for you, do nothing. There will be no hassles. No questions asked.

Administered by:

MERCER
MAKE TOMORROW, TODAY

Mercer Consumer,
a service of Mercer Health & Benefits Administration LLC
P.O. Box 14464
Des Moines, IA 50306-8993

QUESTIONS?
Call: 1-800-882-5541
www.afsainsurance.com

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

100% Endorsed by:

Underwritten by:

THE HARTFORD
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 is private insurance. This insurance is not associated with SGLI.

Your association shares a financial interest in this program, which benefits the entire membership.

Life Form Series includes SRP-1153, or state equivalent.

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