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

Dear AFSA Member,

Thank you for requesting information on AFSA's Term Life Insurance Plan. I'm pleased to send the information you requested.

I've enclosed a brief detailing how you can take advantage of economical group rates — and help give your family MORE protection — with the AFSA Term Life Plan.

For example, a 40-year-old AFSA member is eligible for the following affordable monthly rates:

$15.79 for $50,000.00 protection	$31.57 for $100,000.00* protection

These budget-conscious group rates mean your Term Life protection could cost less than coverage you'd find on your own. Plus, this plan can stand out as a value when you look at plans from other military associations.

Your spouse can take advantage of the savings, too. As a matter of fact, many members take advantage of their AFSA membership to lock in these affordable, group rates for protection of their spouse's life.

And there's more...

Your status as an AFSA member — combined with the buying power of nearly 115,000 other AFSA members — helped AFSA secure valuable benefits for you and your spouse. These desirable benefits are automatically included in your AFSA Term Life Plan — at no additional cost to you!

- You are protected 24 hours a day, 365 days a year — **even if you fly airplanes — there are no military flying or general flying exclusions!**
- You're guaranteed acceptance for up to $20,000.00 of AFSA Term Life protection if you're active duty under age 40 and are enrolling within 60 days of becoming an AFSA member.

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(Continued...)

- Even if you have health problems, you're offered guaranteed acceptance coverage. If, for reasons of health, you or your spouse are not eligible for the coverage you apply for, you will automatically be eligible for $20,000.00 in life coverage. Your first year coverage will be $4,000.00, which will grow by 20% each year for five years up to the maximum benefit amount of $20,000.00.

- You pay **no further premium** if a Sickness or Injury leads to a Total Disability which keeps you from working at your current job. Your full Term Life coverage continues at **100%** — and you owe nothing — if your Total Disability starts before age 60 and you stay Totally Disabled for at least six consecutive months.

- You can collect up to 50% of your AFSA Term Life benefits before you die (or $50,000, whichever is less) if your doctor says you have fewer than six months to live. Your money will be sent right away — to use however you want.

This information is written in connection with the promotion or marketing of the matter(s) addressed in this material. The information cannot be used or relied upon for the purpose of avoiding IRS penalties. These materials are not intended to provide tax, accounting or legal advice. As with all matters of a tax or legal nature, you should consult your own tax or legal counsel for advice.

Getting your paperwork started is as simple as letting us know how much coverage you'd like and answering a few questions.

You don't even need to send money today. In fact, I'd rather you get an AFSA Term Life Certificate of Insurance in your hands first. Then you can see the valuable benefits for yourself before you commit in any way.

I've taken the paperwork as far as I can right now. I need your go-ahead to verify your eligibility for this plan.

Please take a few minutes to review your enclosed Coverage Summary and act on the Term Life Plan today.

Sincerely,

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

P.S. Budget-conscious group rates are just one of the reasons more than 3,000 AFSA members and their families have taken advantage of this Term Life Plan. Now you can, too. Simply complete and return the enclosed application for approval.

*At age 65, or if you are already age 65, all coverage is reduced to a maximum of $50,000.00.

Please read the enclosed fact sheet for more information (including costs, exclusions, limitations, reduction of benefits and terms of coverage) on this plan.

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

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

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ILI648L - AFSA

GROUP TERM LIFE INSURANCE APPLICATION

HARTFORD LIFE INSURANCE COMPANY

Hartford, Connecticut 06155

01437-Q
074030010144

Please Print. **Use Dark Ink.** **Do Not Erase.** **Initial All Changes.** **For Office Use: h w**

Association Name: Air Force Sergeants Association	Policy No.: AGL-1557	Certificate No.: (Leave Blank)

Proposed Insured Name: (First, Middle Initial, Last)	❑ Male ❑	Date of Birth:	Height:___ft.___in. Weight:______lb.
Street: City: State: Zip Code:	Preferred Phone No. ( )	Email Address	
Spouse's Name: (First, Middle Initial, Last), if applying	❑ Male ❑ Female	Date of Birth:	Height:___ft.___in. Weight:______lb.

Beneficiary - Print full name & relationship to you

Name: ____________________________________ Relationship: ____________________________________

The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

Please indicate if request is for:

❑ New Coverage

Member: ❑ $100,000 (00Y1) ❑ $50,000 (00N1) ❑ $20,000 (00G1)

Spouse: ❑ $100,000 (00Y5) ❑ $50,000 (00N5) ❑ $20,000 (00G5)

The Spouse may not be covered under a Plan with benefits greater than 100% of the Member's Plan.

CHILD COVERAGE: ❑ Yes ❑ No

❑ Change in Coverage

Member's Current benefit amount: $_________ Additional benefit requested: $________ Total benefit: $___________

Spouse's Current benefit amount: $_________ Additional benefit requested: $________ Total benefit: $___________

If Dependent Coverage is desired, complete the following:

Full Name	Relationship	Birth Date	Height	Weight

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

PLEASE COMPLETE THE FOLLOWING:	Member YES/NO	Spouse YES/NO
1. In the last 2 years, have you or your Spouse been unable to perform the full-time duties of your occupation for 10 consecutive days, or if not employed, been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90 day period immediately preceding the date of this application for 10 consecutive days?..............................	❑ ❑	❑ ❑
2. 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, 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?..	❑ ❑	❑ ❑
3. 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?..........	❑ ❑	❑ ❑

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.)

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 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 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 Hartford Life Insurance Company 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 or employment status.

Hartford Life Insurance Company 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 Hartford Life Insurance Company.

I authorize Hartford Life 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 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 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.

I certify that I have received the Notice of Insurance Information Practices.

Member's signature (Sign name in full) ____Date ______________________

Spouse's/Domestic Partner's signature (if applying) ______________________________Date ______________________

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

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 law.

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

QUESTIONS?
Call: 1-800-882-5541
E-Mail: afsa.service@mercer.com

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

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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AFSA Term Life Insurance Plan Coverage Summary

Affordable Group Rates

Thanks to the group buying power of more than 115,000 members, you pay an economical members-only rate. See below for your rate.

Monthly GROUP Rates*						
Age	$20,000.00		$50,000.00		$100,000.00**	
	Member	Spouse	Member	Spouse	Member	Spouse
Under 25	$2.68	$1.52	$6.71	$3.80	$13.42	$7.59
25-29	2.82	1.67	7.04	4.18	14.08	8.36
30-34	3.28	1.96	8.20	4.90	16.39	9.79
35-39	4.36	2.57	10.89	6.44	21.78	12.87
40-44	6.31	3.78	15.79	9.46	31.57	18.92
45-49	11.24	6.73	28.11	16.83	56.21	33.66
50-54	19.05	11.42	47.63	28.55	95.26	57.09
55-59	26.40	15.82	66.00	39.55	132.00	79.09
60-64	47.20	28.31	118.00	70.77	236.01	141.51
65-69**	75.14	45.08	187.84	112.69	N/A	N/A
70-74**	117.00	70.20	292.51	175.49	N/A	N/A
75-79**	143.70	106.48	443.67	266.20	N/A	N/A
80-84**	268.56	161.12	641.40	402.80	N/A	N/A

*Other benefit amounts are available from $20,000 up to a maximum of $150,000 in $10,000 increments. For premium rates please call the Plan Administrator at 1-800-882-5541.

$.50 a month protects all your eligible children. Children 14 days to 6 months are eligible for $100.00 coverage and children ages 6 months to 19 years (23 if full time student) are eligible for $2,500.00 coverage.

**For your convenience, you'll be billed just four times a year. Benefit amounts in excess of $50,000 for Member or Spouse will reduce to $50,000 following their attainment of age 65. Spouse benefit amount may not exceed the member's benefit amount. Coverage will terminate upon attainment of age 85. Rates are based on member's attained age and increase as you enter each new age category. Rates and/or benefits may be changed on a class basis.

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.

Eligibility

To be eligible to apply for coverage, you must be under age 65 and a member of AFSA.Your spouse is also eligible for coverage if they are under age 65 and not legally separated or divorced from you.

This coverage is available only for residents of the United States excluding ID, ME, MI, MT, NH and OR.

Exclusions

Suicide during the first two years of coverage is not covered under this plan.

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.

(Next page, please)

Premium Waived for Total Disability

If you become Totally Disabled while insured under this policy prior to your 60th birthday and are continuously disabled for a period of at least six consecutive months, your premium will be waived as long as you remain Totally Disabled and benefits are payable. Total Disability is caused by bodily injury or disease which prevents you from engaging in any occupation or profession for wage or profit; or if not employed, from engaging in the normal and customary activities of a person of like age and sex in good health.

Accelerated Death Benefit

If you are diagnosed as Terminally Ill with less than six months to live, you can collect up to 50% or $50,000 (whichever is less) of your coverage to use however you wish. Your beneficiary will then collect the remainder after your death. (Note: A doctor-certified Terminal Illness means an illness from which no recovery is expected, that results in a life expectancy of six months or less.) The member must be enrolled with at least $10,000 in life insurance and be under age 65. Benefits paid under the accelerated death benefit may be taxable, please consult your personal tax advisor for further information.

This information is written in connection with the promotion or marketing of the matter(s) addressed in this material. The information cannot be used or relied upon for the purpose of avoiding IRS penalties. These materials are not intended to provide tax, accounting or legal advice. As with all matters of a tax or legal nature, you should consult your own tax or legal counsel for advice.

How to Apply

Simply complete the enclosed application. Once you're approved, we'll send you a Certificate of Insurance. You'll have 30 days to review it and decide if this is the coverage you want. If it is, simply pay the bill accompanying your Certificate. If it is not, do nothing. You're under no obligation.

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.

Effective Date

Your Term Life protection will start on the first day of the month after your application has been approved and your first premium has been paid. If you send a check with your application, your coverage will begin on the first day of the month after your application is approved.

If, however, on the date that you are to become covered under the Policy you are confined for medical care or treatment in an institution or at home you will not be so covered until the earlier of the first day of the month on or next following the date you have not been confined for medical care or treatment in an institution or at home.

TERMINATION

You can keep your AFSA Term Life coverage up to age 85 — no matter what your health — as long as the group Master Policy stays in force, you pay your premiums when due and you remain an AFSA member. Coverage for your dependents terminates when they are no longer eligible due to change in age, dependency or marital status.

Administered by:

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

(Next page, please)

Underwritten by:

Hartford Life Insurance Company
Hartford, CT 06155

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

This fact sheet 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 fact sheet 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 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 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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