For Members of the American Occupational Therapy Association

GROUP TERM LIFE 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:
AOTA GROUP INSURANCE PROGRAM
P.O. Box 10374
Des Moines, IA 50306-8812

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

SECTION 1

Association Name: American Occupational Therapy Association	Policy No.: AGL-1956	Certificate No.: (Leave Blank)

SECTION 2

Proposed Insured's Name: (First, Middle Initial, Last)	❑ Male ❑ Female	Date of Birth (MM/DD/YYYY):
Height: ____ft. ____in. Weight: ______lb.	Place of Birth (State/Country):	Phone No.: ( )
Street: City: State: Zip Code:		E-mail Address:

Beneficiary - Print full name & relationship to you
Name:____ Relationship:____
The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

SECTION 3

Spouse/Domestic Partner'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):	

PA-9356 (HLA) (CA) LI648E-1956CA

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SECTION 4

Amount Desired ($50,000 minimum up to $250,000 maximum in $50,000 increments)

Member: ❑ $50,000 ❑ $100,000 ❑ $150,000 ❑ $200,000 ❑ $250,000

Spouse/Domestic Partner: ❑ $50,000 ❑ $100,000 ❑ $150,000 ❑ $200,000 ❑ $250,000

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

Please indicate if request is for:

❑ New Coverage

❑ Change in Coverage

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

Spouse/Domestic Partner's Current benefit amount: $ __________ Additional benefit requested: $__________ Total benefit $:___________

IF REQUEST IS TO CHANGE EXISTING COVERAGE PRINT ONLY ADDITIONAL AMOUNT DESIRED

Child(ren) Coverage ❑ Yes ❑ No

The child benefit is $250 for children under six months and $5,000 for children over age six months. $___________

SECTION 5

PLEASE COMPLETE THE FOLLOWING:	Member YES/NO	Spouse/ Domestic Partner YES/NO
At any time during the past 12 months to the present, have you or your Spouse/Domestic Partner smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff?	❑ ❑	❑ ❑
In the last 2 years, have you or your Spouse/Domestic Partner been unable to perform the full-time duties of your occupation for 10 consecutive days? If not employed, have you or your Spouse/Domestic Partner 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?	❑ ❑	❑ ❑
All questions are answered to the best of my knowledge and belief:		
1 In the past 10 years, have you ever 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 or sleep disorder?	❑ ❑	❑ ❑
C. Colitis, ulcer, kidney disease or disorder, or liver disease or disorder, 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, excluding HIV tests?	❑ ❑	❑ ❑
2 During the past 5 years, have you consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this application; or has anyone proposed for coverage been confined or treated in any hospital, sanatorium or similar institution?	❑ ❑	❑ ❑

SECTION 6

If you answered "Yes" to any of the above medical questions, please explain the details below.

Question Number and Condition	Name of Family Member	Dates	For any question answered "yes" please provide details, your physician's name, full address, and phone number (Required for processing.)

(Attach sheet of paper if additional space is needed.)

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SECTION 7

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 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 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 and Accident 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 except drug and alcohol treatment information.

Hartford Life and Accident 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 and Accident Insurance Company.

I authorize Hartford Life and Accident Insurance Company 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.

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 8

Member's signature (Sign name in full) ______________________________ Date____________________________
Required Required

Spouse/Domestic Partner's signature (if applying) ______________________________ Date__________________________
Required Required

SECTION 9

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/Domestic Partner: ❑ Yes ❑ No

Indicate how you wish to be billed:

❑ Automatic Monthly Check Withdrawal

❑ Semi-Annual Direct Bill

(If you select Automatic Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

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Life Form Series includes GBD-1000, GBD-1100 or state equivalent.

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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:** _____________________________________

Group Term Life Insurance Plan
(with Living Benefit Feature)

FOR AMERICAN OCCUPATIONAL THERAPY ASSOCIATION MEMBERS

AOTA® The American Occupational Therapy Association, Inc.

Read on for 2 ways you can get more protection for less…

1. Your Association's Group Rates

Your Association has made arrangements with Hartford Life and Accident Insurance Company to offer Group Term Life Insurance to eligible members under age 65.

Due to your Association's mass-purchasing power, this plan is available at economical group rates.

2. Lower Rates for Non-Smokers*!

If you haven't used tobacco products in the past 12 months, you're eligible for the non-smokers' rates. As shown in the rate chart that is inside, this varies by age.

*A non-smoker is one who has not smoked cigarettes, cigars or a pipe, or used chewing tobacco, nicotine chewing gum or snuff during the 12 months before submitting an application for life insurance.

Even if you have some Life Insurance, you should consider applying!

Do you have enough life insurance? If you were to pass away, would your loved one have enough money to pay your "final expenses," the mortgage or rent payments, car payments, other financial obligations, living expenses, education expenses, and all the rest? Don't pass up this opportunity to help provide a measure of financial security—$50,000 to $250,000—for your family, at the affordable group rates available to association members.

You're Eligible to Apply if You're Under Age 65.

Each member under age 65 who is a citizen or legal resident of the United States, its territories and protectorates may apply for this coverage.

This coverage is available only for residents of the United States excluding AK, CO, ID, LA, MD, ME, MI, MN, MT, NV, NM, NY, OH, OR, SC, SD, VT, WA and WV.

Exclusions

During the first 2 years of coverage the benefit for death due to suicide will be limited to a refund of premium paid. During the two years immediately following an increase in coverage under The Policy, We will only pay the deceased person's Life Insurance Benefit in an amount equal to the amount of Life Insurance in force prior to the increase, plus an amount equal to the premium paid for the increase to the date of death.

Protection for your Family!

Coverage is available for your lawful Spouse/Domestic Partner, under age 65, from $50,000 to $250,000. Your Spouse/Domestic Partner's premium is based on your age. Spouse/Domestic Partner's coverage is available only if you are insured and may not exceed your amount of insurance. If member and Spouse are both members of AOTA, coverage may not be duplicated by applying as dependents of each other. Children may only be covered under one plan. Benefit amount restrictions for Spouse/Domestic Partner may apply in some states. A Spouse can not be legally separated or divorced from the member. You may also insure each of your unmarried dependent children (from 15 days old to age 26) for one monthly premium of 29¢ per $1,000 of coverage to a maximum of $5,000, no matter how many children you have. Children 15 days to 6 months can be covered for $250.

Your Coverage is Renewable to Age 80

Your insurance cannot be cancelled, up to age 80, as long as your premiums are paid when due, you continue your Association membership, and the Master Policy remains in force. Coverage terminates on the premium due date coinciding with or following your 80th birthday. Dependent coverage terminates when your coverage ends, when you discontinue the payment of premiums, or when dependents no longer satisfy eligibility requirements.

Effective Date of Coverage

When your application is approved by the insurer, your insurance will become effective as of the first of the month coinciding with or following approval and receipt of the first month of premium.

Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford***. 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.

Waiver of Premium if Disabled

Should you become Disabled prior to age 60, and your disability continues for at least six consecutive months while insured, your coverage will continue without premium payments while you continue to be disabled. We'll also waive these premiums for your Spouse/Domestic Partner and covered dependents as long as you are unable to work and remain Disabled. Once a disability ends, premium payments must resume.

Disabled means you are unable to perform any work or occupation for which you are reasonably qualified or trained; or if not employed, engaging in the normal activities of a person of like age and gender in good health or as a result of injury or sickness. In addition, you will be considered disabled if you have been diagnosed with a life expectancy of 12 months or less.

Life Insurance Conversion Right

If coverage terminates for any reason, except for non-payment of premium or reaching the maximum age, you and/or your covered dependents may be eligible to convert the life insurance to an individual policy, underwritten by The Hartford***. The conversion opportunity is limited when coverage terminates due to group policy termination. Details are in your Certificate of Insurance.

Accelerated Death Benefit: "Living Benefit Feature"

The plan permits you take advantage of up to 50% of the death benefit or $125,000, whichever is less, prior to death provided you have been diagnosed to be Terminally Ill, with life expectancy of less than 12 months. These funds can be used for any reason—for medical expenses, to pay off a mortgage, or just to make the final months more comfortable. The balance of the death benefit would go to the assigned beneficiary. Accelerated benefits may be taxable. These materials are not intended to provide tax, accounting or legal advice and cannot be relied upon for any such purpose. We recommend that you consult with a qualified tax advisor. Accelerated benefits may affect your or your family's initial or continued eligibility for public assistance, such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), we recommend that you consult with social service agencies with any questions regarding eligibility for public assistance.

About Your Premiums

The monthly premiums shown below are for your choice of $50,000, $100,000, $150,000, $200,000, or $250,000 in coverage. Spouse/Domestic Partner's premiums are based on the member's attained age. Premiums increase as the member enters a new age bracket. The benefit amount remains constant except due to reductions by age. Rates and/or benefits may change on a class basis.

2 Ways to Pay!

If you choose to pay by Automatic Monthly Check Withdrawal, please complete the request on the application. The premium amount will automatically be deducted from your checking account each month. If you choose to pay by Semi-Annual Direct Bill, multiply your monthly premium by 6. You will be mailed a bill after your application has been accepted.

SEND NO MONEY NOW!

You are not required to send any money until your application is approved. You will be billed on a semi-annual basis later.

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.

Living Benefit Term Life Insurance Plan–Monthly Premiums

Standard Smoker Rates

Member's Age	$50,000	$100,000	$150,000	$200,000	$250,000
Under 30	$4.40	$5.28	$7.92	$10.56	$13.20
30–34	5.28	7.04	10.56	14.08	17.60
35–39	7.20	10.88	16.32	21.76	27.20
40–44	11.76	20.00	30.00	40.00	50.00
45–49	18.56	33.60	50.40	67.20	84.00
50–54	29.08	54.64	81.96	109.28	136.60
55–59	45.52	87.52	131.28	175.04	218.80
60–64	68.96	134.40	201.60	268.80	336.00
65–69*	112.00	220.56	330.84	441.12	551.40
70-74	186.63	367.53	551.30	735.06	918.83
75-79*	319.76	629.70	944.55	1,259.41	1,574.26

Standard Non-Smoker Rates

Member's Age	$50,000	$100,000	$150,000	$200,000	$250,000
Under 30	$3.68	$3.92	$5.88	$7.84	$9.80
30–34	4.40	5.28	7.92	10.56	13.20
35–39	5.60	7.76	11.64	15.52	19.40
40–44	9.12	14.72	22.08	29.44	36.80
45–49	14.36	25.20	37.80	50.40	63.00
50–54	23.48	43.44	65.16	86.88	108.60
55–59	37.48	71.44	107.16	142.88	178.60
60–64	58.48	113.44	170.16	226.88	283.60
65–69*	98.00	192.24	288.36	384.48	480.60
70-74	163.30	320.34	480.51	640.68	800.85
75-79*	279.79	548.85	823.27	1,097.70	1,372.12

Spouse/Domestic Partner Coverage**
(from $50,000 – $250,000)

Per $10,000 Unit	
Under 30	1.40
30–34	1.75
35–39	2.37
40–44	3.50
45–49	5.52
50–54	8.75
55–59	13.57
60–64	18.90
65–69*	30.80
70-74	51.32
75-79*	87.93

*For renewal only.
Children's coverage: 29¢ monthly per $1,000 of coverage to a maximum of $5,000.
Rates are based on member's attained age and will increase as the member enters a new age bracket. Rates and/or benefits may be changed on a class basis. At age 65, benefits are reduced by 50% and by an additional 50% at age 75 with an appropriate adjustment in premium.
**Spouse/Domestic Partner rates are shown in $10,000 units. To determine your monthly rate, multiply the rate shown above by the number of $10,000 units you are applying for.

A non-smoker is one who has not smoked cigarettes, cigars or a pipe, or used chewing tobacco, nicotine chewing gum or snuff during the 12 months before submitting an application for life insurance.

Administered by:

Mercer Consumer, a service of Mercer Health &
Benefits Administration LLC
P.O. Box 10374
Des Moines, IA 50306-8812

Questions?
Phone: 1-800-503-9230
www.aotainsurance.com

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

Underwritten by:

Hartford Life and Accident Insurance Company
Hartford, CT 06155

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company Hartford Life and Accident Insurance Company.

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. This program may vary and may not be available to residents of all states.

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HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Notice of Information Practices

This notice applies to residents of: All states, excluding Massachusetts.

The Hartford Life and Accident Company respects your right to privacy and values your trust. This Notice explains how we collect, use and protect your personal information and your rights regarding that information.

Information We Collect: While your application for insurance is our primary source of information about you, we may also need to collect or verify information from other sources such as physicians and other medical and health care providers and professionals, health facilities such as hospitals, clinics, pharmacies, employers, consumer reporting agencies, and insurance-support organizations, which may provide us with an investigative consumer report about you. Organizations that provide us with consumer reports about you may disclose the contents of the report to others for which such organization performs such services. We may collect personal information about you that is necessary to determine your eligibility for insurance, to service your insurance policy, and otherwise as permitted by law; the information may include information from which judgments can be made about your age, health and medical history, occupation, avocations, finances, credit, character, habits, general reputation, or any other personal characteristics. We also collect information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment and claims history.

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 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 Model 400, Braintree, Massachusetts 02184-8734. 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.

Disclosure of Personal Information: We will not disclose your personal information to third parties without your authorization except in connection with our business or as otherwise permitted or required by law. For example, in connection with our general business practices, we may disclose personal information we collect to: companies performing services or functions on our behalf, including other insurers, agents or insurance support organizations, including for the purpose of determining your eligibility for insurance benefits or payments; detect or prevent fraud or criminal activity in connection with insurance transactions; medical care institutions or medical professionals for the purposes of verifying coverage or benefits; insurance regulatory authorities or law enforcement of other governmental authorities to prevent or prosecute the perpetration of fraud; the policyholder of a group insurance policy (for example an employer who provides group insurance) for purposes of reporting claims experience, conducting an audit of our operations or services, risk mitigation or other permissible purposes; third parties who collect data regarding claims for purposes of underwriting and claims handling, or to a third party as otherwise permitted or required by law; or reinsurers.

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Form PA-10210 (2018)

How We Protect Your Information: We employ administrative, technical and physical safeguards to protect the security, confidentiality and integrity of personal information. We will continue to protect your information even when a business relationship no longer exists between us.

Right to Access and Right to Correct/Amend/Delete: You have the right to learn what personal, including medical, information we have in our files about you, to whom it has been recently disclosed, to have access to the information, to correct the information, and to receive a copy. We are not required to provide you access to information that is collected when we evaluate a claim or when the possibility of a lawsuit exists.

Please contact us if you would like access to your information from your files. There may be a reasonable charge for copies of records. If you think your file contains incorrect information, notify us indicating what you believe is incorrect and your reasons. We will investigate the matter and either correct our records or place a statement from you in our files explaining why you believe the information is incorrect. We will also notify persons or organizations to whom we previously disclosed the information of the change or your statement.

If you request access to medical record information that was supplied to us by a medical care institution or medical professional, we may choose to provide it to a medical professional designated by you.

Rights Relating to Adverse Underwriting Decision: You have the right to certain information relating to adverse underwriting decisions we may make about You, including the reason for such decision. In the event we make an adverse underwriting decision relating to You, we will provide You with information regarding such decision and Your rights.

How to make a request: If you wish to exercise your rights as provided in this notice, please provide us with your full name, complete address, your policy number or other identifying information and a reasonable description of the information you wish to access or correct. Please send your written request to: The Hartford, Attn: Medical Underwriting, PO Box 2999, Hartford, CT 06104-2999.

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