For Members of the American Speech-Language-Hearing Association

GROUP TERM 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:

ASHA GROUP INSURANCE PROGRAM
P.O. Box 10374
Des Moines, IA 50306-8812

ASHA
American
Speech-Language-Hearing
Association

Section 1

Association Name: American Speech-Language-Hearing Association	Policy No.: AGL-1948

Section 2

Member's Name: (First, Middle Initial, Last)	❑ Male ❑ Female	Date of Birth (MM/DD/YYYY):	
Height: ____ft. ____in. Weight: _____lb.	Place of Birth (State/Country):		Daytime Phone No.: ( )
Street:	City:	State:	Zip Code:

Member's Beneficiary - Print full Name & relationship to you
Name:_____Relationship:_____
The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

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):	

PA-9356 (HLA) (CA)

TL648E-AGL1948CASI

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Section 4

Please select:

Member:

❑ $10,000 ❑ $20,000 ❑ $30,000 ❑ $40,000 ❑ $50,00 ❑ $60,000 ❑ $70,000 ❑ $80,000 ❑ $90,000 ❑ $100,000 ❑ $110,000

❑ $120,000 ❑ $130,000 ❑ $140,000 ❑ $150,000

Spouse:

❑ $10,000 ❑ $20,000 ❑ $30,000 ❑ $40,000 ❑ $50,00 ❑ $60,000 ❑ $70,000 ❑ $80,000 ❑ $90,000 ❑ $100,000 ❑ $110,000

❑ $120,000 ❑ $130,000 ❑ $140,000 ❑ $150,000

Section 5

All questions are answered to the best of my knowledge and belief:	Member/ Primary Insured	Spouse
1 During the last 5 years, have you or your spouse been diagnosed 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?	❑ Yes ❑ No	❑ Yes ❑ No
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?	❑ Yes ❑ No	❑ Yes ❑ No
3 Have you or your spouse been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity)?	❑ Yes ❑ No	❑ Yes ❑ No

Section 6

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 approvaland 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 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 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 under stand that the Company may request whatever additional evidence of insurability it needs.

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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.

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'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: ❑ Yes ❑ No

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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.)

QUESTIONS?
Call: 1-866-795-9340
E-Mail: customerservice.service@mercer.com

TL648E-AGL1948CASI
Policy Number AGL-1948

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

PA-9356 (HLA) (CA)

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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:** _____

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Group Term Life Insurance Plan

For ASHA Members

The ASHA Term Life Insurance Plan may be for you.
To help you look after your family ...so your family isn't left facing stacks of bills when you're not there anymore to help.

Why Buy Life Insurance? Throughout your life you've gained many responsibilities and commitments. Life insurance can help you keep the promises you made in several ways. The proceeds of a life insurance policy may be needed to help …

- pay off a mortgage or continue rent payments
- provide an education fund for your children
- pay off business debts or other financial obligations
- pay taxes on your estate
- pay large medical bills due to a prolonged illness
- provide money for other financial needs your survivors may face

The ASHA Term Life Insurance Plan is designed to help provide you and your family sound financial protection at reasonable group rates. If you are under age 65 you have the opportunity to apply for up to $150,000 of life insurance protection in $10,000 units for yourself and for your Spouse, and up to $2,500 for each of your eligible children. Children 15 days to 6 months can be covered for $500. Plus, you can receive up to one-half of your chosen benefit before you die should you be diagnosed as Terminally Ill.

Take a positive step towards helping to secure your family's financial future and review the ASHA Term Life Insurance Plan today! Then complete the Application and return it with your first semi-annual premium payment.

Living Benefits Life. The Living Life Benefit!

Most people purchase life insurance to gain peace of mind in knowing that they are helping their families become financially secure when they die. With Living Benefits Life, members can gain added peace of mind for themselves and their families before they die should they become Terminally Ill. A Terminal Illness is a condition where your life expectancy is 24 months or less. This must be confirmed in writing by a physician licensed to practice in the United States, and supportive evidence may be required by the Insurance Company.

Treatment, nursing care, hospitalization, nursing home confinement, hospice care and other expenses associated with a Terminal Illness can cost thousands of dollars. Not only could a Terminal Illness cause large medical bills, it could also force your income to stop.

With the Living Life Benefit you may elect to receive up to one-half of the total benefit amount of your Group Term Life Insurance Plan prior to death if you are diagnosed as being Terminally Ill. (These living or "accelerated" benefits may be taxable, so please consult your personal tax advisor.*) Then, the amount of your total benefit that is not used as part of your Living Life Benefit will be paid directly to your beneficiary upon your death.

If you do not use the living or "accelerated" benefit provision of this Plan, your full benefit would be paid to your beneficiary upon your death. Your beneficiary will not have to pay federal income taxes on these benefits based on current tax laws (please consult a tax advisor for further information*).

The Living Life Benefit is a practical way to help complement your existing insurance plans including health, disability and life. It would pay you a valuable benefit at a time when high medical bills and loss of income could put your family's financial security at risk. And the benefits are paid directly to you in a lump sum payment for you to spend however you wish.

*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.

Eligibility

You and your Spouse are eligible for coverage if you are a member of the Association, under age 65. Spouse cannot be legally separated or divorced from you. Your dependent children are also eligible for coverage if they are under 26 years of age and primarily dependent on you. When you/your spouse are both Eligible Members:

1) coverage may not be duplicated by applying as dependents of each other; and 2) coverage for an Eligible Dependent Child may be requested by either you or your spouse, but not both.
No Eligible Child will be covered unless either the Eligible Member or the Eligible Spouse is covered.

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

How much coverage can I apply for?

If you are under age 65 you have the opportunity to apply for up to $150,000 of life insurance protection in $10,000 units for yourself and for your Spouse, and up to $2,500 for each of your eligible children. Children 15 days to 6 months can be covered for $500.

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.

IMPORTANT FEATURES:

Reasonable Cost

Your premiums are affordable through the economies of centralized group administration.

Waiver of Premium for Disability

If you are Disabled before you reach age 60 and remain disabled for six consecutive months, your insurance will remain in force without further premium payments as long as you are disabled or attain the policy age limit. When your disability ends, premium payments resume.

Disabled means you are wholly and continuously prevented from:
1) performing any work or occupation for wage or profit for which You are reasonably qualified or trained; or 2) if not employed, engaging in the normal activities of a person of like age and gender in good health; as a result of injury or sickness.

If You are in an occupation that requires You to maintain a license, Your failure to pass a physical examination required to maintain that license does not alone mean that You are disabled.

Complete Coverage

Your insurance is payable in the event of death from any cause (except suicide during the first two years) ... at any time ... in any place. This coverage can also be maintained when you change employers.

Your Choice of Beneficiary

You may name anyone as your beneficiary. You may change your beneficiary at any time by writing the Insurance Administrator.
Upon proof of death, your beneficiary receives the benefit in a lump sum or monthly installments, whichever the beneficiary wishes. You are automatically the beneficiary of your children's insurance. If you do not name a beneficiary the insurance amount will be paid to your survivors, in equal shares, to first your spouse; children; parents; brothers and sisters or to your estate.

Effective Date

Your coverage will become effective after your application is approved by The Hartford and the receipt of the first month premium has been received by the administrator.

Renewability

As long as you pay your premiums, you remain a member of the Association, and the Master Policy is not terminated by the Insurance Company, your coverage cannot be cancelled. Your insurance is renewable to age 90. Your dependents are insured as long as your coverage remains in force, their premiums are paid and they continue to meet the eligibility requirements of the Plan.

Conversion Rights

You may convert your group life insurance if your coverage ends for any reason except non-payment of premium, for up to the same amount of life insurance to any individual life policy, other than term, underwritten by the Insurance Company. Complete conversion rights are outlined in your Certificate.

Exclusion

Suicide while sane or insane is not covered during the first two years you are insured. During the first two years of coverage under the Policy an amount equal to the premium paid for coverage to the date of death will be paid. During the two years immediately following an increase in coverage under The Policy, The Hartford 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.

Termination

Coverage will end on the earliest to occur of: 1) the date The Policy terminates; or 2) the Premium Due Date on or next following the date You attain the Policy Age Limit; 3) the date You are no longer in a class eligible for coverage, or the class is cancelled; or 4) the Premium Due Date that You fail to pay any required premium, subject to the Individual Grace Period.

YOUR SEMI-ANNUAL PREMIUM
Applicant or Spouse
PER $10,000 UNIT of COVERAGE

Age	Male	Female
Under age 30	$8.30	$5.52
30–34	9.22	7.34
35–39	12.86	10.08
40–44	21.12	15.60
45–49	36.82	23.04
50–54	59.76	34.08
55–59	91.10	51.50
60–64	145.34	79.10
65–69*	207.94	127.92
70–74*	195.84	162.58
75–79*	286.32	237.31
80–84*	215.71	178.90
85-89*	309.22	256.61

* For renewal only.

Rates are based on the attained age of the Insured Person and increase as you enter each new age category.

[1]Benefits reduce by 50% once member or spouse reach the ages of 70. At age 80, the benefit will be further reduced by 75% with appropriate adjustments in premium.

Coverage terminates at age 90. Rates and/or benefits may be changed on a class basis only.

$3.64 rate covers each eligible dependent child, age 6 months to 26 years, for a benefit of $2,500 (under 6 months for a benefit of $500).

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.

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.

Program Offered by:

Association Member Benefits Advisors, LLC., which acts as the insurance broker for the Group Policyholder, is appointed by The Hartford, and is compensated for the placement of insurance.

In CA d/b/a Association Member Benefits & Insurance Agency

CA Insurance License #0I96562 | AR Insurance License #100114462

P.O. Box 10374
Des Moines, IA 50306-8812

Questions?
1-866-795-9340
www.slhadvisor.com

30-Day Free Look — you have 30 days to look over your plan of insurance and discuss it with your family and advisors. If for any reason you're not satisfied, you may return your certificate within 30 days of your effective date of coverage for a full refund, minus any claims paid.

Underwritten by:

Hartford Life and Accident Insurance Company
Hartford, CT 06155

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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 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.

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

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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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