

**DISABILITY INCOME 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:  
ICPAS GROUP INSURANCE PROGRAM  
P.O. Box 10374  
Des Moines, IA 50306-8812



**Section 1**

Association Name: Illinois CPA	Policy No.: AGP-5891	Certificate No.: (Leave Blank)
--------------------------------	-------------------------	--------------------------------

**Section 2**

Name: (First, Middle Initial, Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: ____ ft. ____ in. Weight: ____ lb.	
Street:		City:		State:
Date of Birth (MM/DD/YYYY):		Age Last Birthday:		Place of Birth (State/Country):
Daytime Phone No.: ( )	Business Telephone: ( )	Email Address: _____		
Occupation:			Pre-Disability Earnings: \$ _____	
Business Address: Street:				
City:			State:	Zip Code:

**Section 3**

Spouse/Domestic Partner's Name: (First, Middle Initial, Last), if applying		<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: ____ft. ____in. Weight: ____lb.	
Street:	City:		State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Age Last Birthday:		Place of Birth (State/Country):	
Spouse/Domestic Partner's Occupation:				
Daytime Phone No.: ( )			Business Telephone: ( )	
Pre-Disability Earnings: \$ _____				
Business Address: Street:				
City:		State:		Zip Code:

**Section 4**

<p><b>COVERAGE REQUESTED:</b></p> <p><b>Member Coverage:</b></p> <p><input type="checkbox"/> New Coverage: Monthly Benefit Amount: \$ _____</p> <p><input type="checkbox"/> Change in Coverage: Increase my Monthly Benefit Amount to: \$ _____</p> <p><input type="checkbox"/> Change in Elimination Period: <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days</p> <p><b>Spouse/Domestic Partner Coverage:</b></p> <p><input type="checkbox"/> New Coverage: Monthly Benefit Amount: \$ _____</p> <p><input type="checkbox"/> Change in Coverage: Increase my Monthly Benefit Amount to: \$ _____</p> <p><input type="checkbox"/> Change in Elimination Period: <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days</p>
--

**Section 5**

Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, give details:						
Name	Company	Monthly Benefit	Benefit Period	Elimination Period	To be replaced?	
					Yes	No
Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 30 hours per week) 90 days before the date of this application? You: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse/Domestic Partner: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Pre-Disability Earnings minus any Other Income Benefits? You: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse/Domestic Partner: <input type="checkbox"/> Yes <input type="checkbox"/> No						

**Section 6**

**Member**      **Spouse/  
Domestic  
Partner**

		<b>YES/NO</b>	<b>YES/NO</b>
All questions are answered to the best of my knowledge and belief:			
<b>1</b>	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 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?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>2</b>	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?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<b>3</b>	Is anyone proposed for coverage now pregnant? If yes, Name: _____ When is the baby due? _____ What was your pre-pregnancy weight? _____ Are there any medical complications?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

**Section 7**

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. Sign and date additional sheet of paper.)

**Section 8**

**AUTHORIZATION**

I hereby certify that I have read or have had read to me 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 pay the 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 physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage.

Hartford Life and Accident Insurance Company will use the information to decide if and to what extent I am 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: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I may apply for Life or Health Insurance, or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my coverage or, 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**

I wish to pay my premiums:  Automatic Monthly Check Withdrawal     Semi-Annual Direct Bill  
(If you select Automatic Monthly Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

**SECTION 10**

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

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

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

**QUESTIONS?**

Call: 1-800-503-9230

E-Mail: [customerservice.service@mercero.com](mailto:customerservice.service@mercero.com)

PA-9357 (HLA) (CA) (2-12)

Disability Form Series includes GBD-1000, GBD-1200 or state equivalent.

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

## 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** \_\_\_\_\_

**THIS PAGE IS INTENTIONALLY LEFT BLANK.**

**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:** \_\_\_\_\_

**THIS PAGE IS INTENTIONALLY LEFT BLANK.**



# Disability Income Insurance Plan



**Don't Let A Disabling Injury or Sickness Harm Your Family's Financial Security...**

**Help make sure your financial future is secure with Disability Income Insurance**

## Up to \$6,000 in Monthly Benefits

Member and/or Spouse/Domestic Partner under age 65, who have been Actively at Work (at least 30 hours per week), may apply for up to \$6,000 per month in disability income benefits. A Spouse cannot be legally separated or divorced from the Member. When Spouses or Domestic Partners are both Eligible Members, coverage may not be duplicated by applying as dependents of each other.

This coverage is available only for residents of the United States excluding AK, AR, CO, DE, IA, LA, ME, MD, MO, MT, NC, NH, NM, OR, TX, UT and WA.

## Choose Your Monthly Benefit

You may choose benefit amounts from a minimum of \$100, up to \$6,000, in \$100 increments. The Monthly Benefit payable will be subject to the Offset Provision stated below. In no event will the Monthly Benefit elected exceed 60% of the Insured Person's Pre-Disability Earnings. Once Totally Disabled, benefits will begin on the first day following completion of your selected Elimination Period (60, 90, or 180 days).

## Offset Provision

The benefit amount payable as the result of the Insured Person's Total Disability will be the lesser of: 1) the Monthly Benefit; or 2) 70% of the Insured Person's Pre-Disability Earnings minus: a) any Other Income Benefits; and b) all other income from any employer or for any work. However, if the Insured Person's Monthly Benefit would reduce to less than \$50 per month due to Other Income Benefits, then the minimum Monthly Benefit under The Policy will be \$50 per month.

This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the Policy:

Insured's Gross Monthly Income	\$3,000.00
Long term disability benefits percentage	x 60%
Unreduced maximum benefit	\$1,800.00
Less Social Security disability benefit per month	- \$900.00
Less state disability income benefit per month	- \$300.00
Total amount of long term disability benefit per month	\$600.00

## Benefit Period

For Total Disability caused by a covered Sickness or Injury, benefits will be paid as follows:

Up to age 65 if Total Disability occurs before attainment of age 63.  
If Totally Disabled at ages 63 through 69, benefits will be payable up to 2 years, but not beyond age 70.

## Recurrent Disability

If you have multiple periods of disability, in order to requalify for full benefit periods, each disability period must either be separated by less than 3 months during which the insured is Actively at Work, or the later Total Disability is caused by an unrelated cause.

## Rehabilitative Employment Benefit

A vocational rehabilitation program is available with staff nurses and specially trained counselors. Each individual rehabilitation program is custom tailored to each claimant's needs. Our counselors use skills assessment, job and transferable skills analysis, job modification, vocational testing, job placement assistance and retraining. The monthly benefit is reduced by 50% for any rehabilitative employment income you receive.

## Successive and Concurrent Disabilities Limitation

The insured member will receive their selected benefit for disabilities, which are recurrent in nature. Successive periods of the same or related disabilities are payable as new benefit periods (eligible for new maximum durations) when separated by six consecutive months of full-time active employment. Periods of disability, if due to the same or related medical causes and separated by fewer than six months while you are Actively-at-Work, are considered a single period of disability.

Periods of disability from entirely unrelated causes are considered separate periods of disability.

Benefits during any Period of Disability as the result of: more than one Sickness; or more than one Injury; or both Sickness and Injury; will be considered the same as if the Disability resulted from only one cause.

## Effective Date

Your insurance will become effective on the first of the month following the date of approval of your application, provided the required premiums are paid. Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford<sup>1</sup>. 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.

## Deferred Effective Date

If on the date You or Your Spouse are to become covered under the Policy for increased benefits; or for a new benefit and You or Your Spouse are not Actively at Work on that date, coverage will not begin until the first day of the month on or next following the date You or he or she are Actively at Work for 1 month.

## Termination of Coverage

Coverage continues as long as: you remain an association member; you pay your premiums on time; you remain Actively at Work (except by reason of Total Disability covered by this plan); the master policy is in effect; and you remain under 70. Your spouse/domestic partner's coverage will remain in effect as long as your coverage is active, premiums are paid, and they meet the eligibility requirements.

## TERMS OF COVERAGE

### Exclusions

This Policy does not cover any Disability or loss caused by: 1) intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane; or 2) pregnancy or childbirth, except Complications of Pregnancy; or 3) war or act of war, whether declared or not; or 4) Your commission or attempted commission of a felony; or 5) Sickness contracted or Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority.

We will refund the pro rata portion of any premium paid for You while You are in the armed forces on full-time active duty for a period of two months or more. Written notice must be given to Us within 12 months of the date You enter the armed forces.

### Waiver of Premium

If you become Totally Disabled, and the Total Disability continues for 6 months, you won't have to pay your premiums for as long as the Total Disability lasts and benefits are payable.

### Monthly Rates per \$100 Monthly Benefits

Select the monthly income you need, from \$100 to \$6,000.

Premiums are based on your selected Elimination Period, age when entering the program, and changes as each new age bracket is reached. The Insurance Company reserves the right to change rates.

## Mental Nervous Disorder Limitation

If You or Your Spouse are Totally Disabled due to Mental Illness, alcoholism or Substance Use Disorder, the Maximum Payment Period will be reduced to 2 years during Your or Your Spouse's lifetime unless You or Your Spouse are confined in a hospital or other institution licensed to provide care and treatment for that disability.

## Defined Terms

**Injury** means bodily injury which results directly from accident and independently disease or bodily infirmity which occurs while You or Your Spouse are covered under the Policy.

**Total Disability** means disability which, during the Elimination Period and the first 24 months during which Total Disability Benefits are payable, wholly and continuously prevents You or Your Spouse from performing the Essential Duties of Your or Your Spouse's Occupation after that, wholly and continuously prevents You or Your Spouse from engaging in Any Occupation.

**Pre-disability Earnings** means, if You or Your Spouse are self-employed, Your or Your Spouse's average net monthly income (gross revenues less business expenses) from: 1) the personal practice of Your or Your Spouse's profession; or 2) personal conduct of Your or Your Spouse's main business. This average is based on net income for: 1) 12 months; or 2) 24 months; whichever produces the higher average, before the determination is made. If You or Your Spouse have been self-employed for less than 12 months, it is based on the whole time You or Your Spouse were self-employed. If Your or Your Spouse's practice is incorporated, net income includes the cost to Your or Your Spouse's company of fringe benefits and Your or Your Spouse's share of total surplus. Income does not include investment returns, rents, royalties, and the like income which is not directly produced from Your or Your Spouse's current work.

Pre-disability Earnings means, if You or Your Spouse are not self-employed, Your or Your Spouse's regular monthly rate of pay, not counting commissions, bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the last day You or Your Spouse were Actively at Work before You or Your Spouse became Disabled.

### Semi-Annual\* Premiums per \$100 Monthly Benefit Amount

(Maximum \$6,000 a month or 60% of your Pre-disability Earnings)

Elimination Period

Your Age	60 days	90 days	180 days
Under 30	\$5.00	\$3.00	\$2.00
30-39	12.00	7.00	6.00
40-49	23.00	16.00	14.00
50-59	40.00	30.00	27.00
60-69**	21.00	16.00	13.00

\*All Premiums apply at attained age on each premium due date. Rates and/or benefits may be changed on a class basis.

\*\*Premiums for ages 65 and over are for renewal only.

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

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.

## It's Easy to Apply!

1. Complete, date and sign the Application. If your spouse/domestic partner is also applying, please complete the form and sign where indicated.
2. **Send no money now.** You will be billed when your Certificate is issued.
3. Mail your completed Application in the enclosed return envelope for approval.  
ICPA GROUP INSURANCE  
P.O. Box 10374  
Des Moines, IA 50306-8812

### 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 #0196562 | AR Insurance License #100114462

P.O. Box 10374  
Des Moines, IA 50306-8812  
  
1-800-842-ICPA (4272)  
[www.icpasinsurance.com](http://www.icpasinsurance.com)

## Underwritten by:



Hartford Life and Accident Insurance Company  
Hartford, CT 06155

<sup>1</sup>The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

Policy Number: AGP-5891

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

Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

DI648P-AGP5891

Copyright 2023 AMBA. All rights reserved.

# 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](http://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.

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

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.

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

Form PA-10210 (2018)