For Minnesota Society of Certified Public Accountants

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 provided envelope **to return to:**

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

MN CPA MINNESOTA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS

Section 1

Association Name: Minnesota Society of Certified Public Accountants	Policy No.: AGP-5885	Certificate No.: (Leave Blank)

Section 2

Name: (First, Middle Initial, Last)	❑ Male ❑ Female	Height: ____ft. ____in. Weight: _____lb.	
Street:	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Place of Birth (State/Country):	Daytime Phone No.: ( )	
Fax Number: ( )	Email Address:_____	Pre-Disability Earnings:	

Section 3

Spouse's Name: (First, Middle Initial, Last), if applying	❑ Male ❑ Female	Height: ____ft. ____in. Weight: _____lb.	
Street:	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Place of Birth (State/Country):	Daytime Phone No.: ( )	
Fax Number: ( )	Email Address:_____	Pre-Disability Earnings:	

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Section 4

COVERAGE REQUESTED:

Member Coverage: Choose your Coverage : ❑1 ❑ 2

❑ New Coverage: Monthly Benefit Amount: $_____

❑ Change in Coverage:

Increase my Monthly Benefit Amount to: $ _____

❑ Change in Elimination Period:

❑ 30 days ❑ 90 days ❑ 180 days

Spouse Coverage: Choose your Coverage : ❑ 1 ❑ 2

❑ New Coverage: Monthly Benefit Amount: $_____

❑ Change in Coverage:

Increase my Monthly Benefit Amount to: $ _____

❑ Change in Elimination Period:

❑ 30 days ❑ 90 days ❑ 180 days

Section 5

Is the Monthly Benefit Amount herein applied for equal to or less than 66 2/3% of your Pre-Disability Earnings?
You: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

Section 6

ALL QUESTIONS ARE ANSWERD TO THE BEST OF MY KNOWLEDGE AND BELIEF:

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
1. During the last 5 years, have you or your Spouse been diagnosed or been treated for cancer, tumor, high blood pressure, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any disease or disorder of the glands, any lung or respiratory disorder, liver, kidney or genitourinary disorder, alcohol or drug dependency, mental or nervous disorder, bone, joint, back, muscle or connective tissue disorder, or chronic fatigue syndrome?	❑	❑	❑	❑
2. Have you or your Spouse ever been diagnosed or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	❑	❑	❑	❑
3. Have you or your Spouse been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity)?	❑	❑	❑	❑

Section 7

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

We understand that coverage will not become effective until the Company grants its underwriting approval and the administrator is in receipt of the first payment of premium. We do not receive temporary or conditional insurance coverage just because we submit an application.

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

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.

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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.

I further understand that any condition excluded or limited by the policy or by a Health Waiver attached to my certificate will not be covered under this policy at any time.

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'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: 1-800-732-8350
E-Mail: customerservice.service@mercer.com

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

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

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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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Disability Income Insurance Plan

MINNESOTA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS

THIS PLAN HELPS PROVIDE AN INCOME WHEN YOU CAN'T WORK

If a covered disabling Injury or Sickness suddenly took away your ability to work and as a result also took away your ability to earn a paycheck…how would you continue to afford the living expenses you must now pay? With the Disability Income Insurance Plan sponsored by your association, your income would continue in the form of a monthly benefit that you select. Don't let a disability rob you of your income.

WHO CAN APPLY?

Members and their legal spouse who are Actively-at-Work (at least 30 hours per week), are under age 60 may apply for this coverage.

The Eligible Member must apply for coverage in order to apply for coverage for his or her Spouse. If both are Eligible Members, only one may apply for coverage as a member of the Policyholder and the other may be covered as a Spouse only.

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

HOW THIS PLAN WORKS

Plan 1: Under this plan, you will receive a monthly benefit beginning on the 31st, 91st or 181st day of your covered Total Disability up to age 65 if Totally Disabled before age 64. For a Total Disability beginning on or after age 64, but before age 70, benefits will be payable for a maximum of 12 months.

Plan 2: Under this plan, you will receive a monthly benefit beginning on the 31st, 91st or 181st day of your covered Total Disability up to age 65 for Injury or up to two years for Sickness. For a Total Disability resulting from an accident, beginning on or after age 64, but before age 70, benefits will be payable for a maximum of 12 months.

YOUR CHOICES

Plan 1 or Plan 2: Determine the maximum amount of time to receive benefits.

Elimination Period: Your benefits will begin on the 31st, 91st, or 181st day of Total Disability.

Benefit Amount: Select from $500 to $4,000 per month (not to exceed 66 2/3% of your Pre-Disability Earnings). Plus, this Plan pays in addition to any other disability benefits you might receive. Any recurrent Total Disabilities are also covered.

IMPORTANT PLAN FEATURES

Managed Disability Approach

The Managed Disability approach encourages a healthy lifestyle through prevention and wellness programs. When an individual becomes disabled, they are helped with rehabilitation and motivation to return to work as soon as reasonably possible.

Successive and Recurrent Disabilities Limitation

The insured member will receive their selected benefit for disabilities, which are recurrent in nature. Recurrent 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 Successive 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 and your Spouse's insurance will become effective on the first of the month on or next following the date of approval of your and your Spouse's application, provided the required premiums are paid. However, your Spouse's coverage will not become effective prior to the date your coverage becomes effective. Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford[1]. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s), or other evidence of good health may be required. Any exams/ tests requested by the company will be conducted at your convenience and at no expense to you.

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 Your Spouse are Actively at Work for 1 month.

Satisfaction Guaranteed

When you receive your Certificate of Insurance, review it carefully. If you are not completely satisfied with the terms of your coverage, simply return your Certificate within 30 days and premiums you have paid will be promptly refunded, minus any claims paid.

IMPORTANT DEFINITIONS

Total Disability

You or your spouse are considered totally disabled if you or your spouse have a disability during the Elimination Period and the following 60 months that prevents you or your spouse from performing the essential duties of your or your spouse's occupation. Thereafter, you or your spouse are totally disabled if you or your spouse are continuously unable to engage in any occupation for which you or your spouse are qualified by education, training or experience.

Pre-Disability Earnings

- If you or your spouse are self-employed, your average net monthly income after business expenses for 12 months or 24 months, whichever produces the higher average, or
- If you or your spouse are not self-employed, your or your spouses regular monthly pay (not commissions, bonuses, tips and tokens, overtime pay or other fringe benefits/extra compensation) immediately prior to the date you or your spouse became disabled.

CONVENIENT PAYMENT OPTIONS

You are able to choose between two premium payment options, whichever one best suits your needs:

Option 1: Automatic Monthly Check Withdrawal. Your premium will be automatically deducted from your checking account on a monthly basis. This not only saves you time, but you don't have to worry about missing a payment.

Option 2: Semi-Annual Direct Bill.

TERMS OF COVERAGE

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 disability covered by this plan); the Master Policy is in effect; and, you remain under 70.

Your spouse's coverage will remain in effect as long as your coverage is active, premiums are paid, and they meet the eligibility requirements.

Exclusions and Limitations

This Policy does not cover any Disability or loss caused by: intentionally self-inflicted Injury; war or act of war, whether declared or not; or 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.

Semi Annual Individual Premiums
Rates Per $100 of Monthly Benefit Amount
Plan 1

Attained Age	30 Day Elimination Period	90 Day Elimination Period	180 Day Elimination Period
Under 30	$4.14	$2.87	$2.58
30-39	6.32	4.17	3.76
40-49	13.65	10.90	9.81
50-59	24.09	24.14	21.73
60-69*	19.00	20.21	18.19

Semi Annual Individual Premiums
Rates Per $100 of Monthly Benefit Amount
Plan 2

Attained Age	30 Day Elimination Period	90 Day Elimination Period	180 Day Elimination Period
Under 30	$3.12	$2.97	$2.68
30-39	4.14	3.94	3.55
40-49	6.95	6.66	6.00
50-59	11.35	11.97	10.78
60-69*	17.05	19.16	17.25

Rates and/or benefits will not be changed unless they are changed for all insureds in your classification.
Rates are based on the attained age of the Insured person and increase as you enter each new age category.
*Renewal premiums only.

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.

HOW TO APPLY

1. Complete, date and sign the enclosed Application. If your spouse 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, for approval, in the enclosed return envelope.

MNCPA 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 #0I96562 | AR Insurance License #100114462

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

QUESTIONS?
1-800-732-8350
www.mncpa-insurance.com

Underwritten By:

Hartford Life and Accident Insurance Company
Hartford, CT 06155

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

This 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

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.

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

Policy Number AGP-5885

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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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