For Members of the Professional Golfer's Association of America

GROUP DISABILITY INCOME INSURANCE APPLICATION

THE HARTFORD

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

PGA

Section 1

Association Name: The Professional Golfer's Association of America	Policy No.: AGP-5887	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:_____		

Section 3

COVERAGE REQUESTED:
Member Coverage:
❑ New Coverage: Monthly Benefit Amount: $_____

❑ Change in Coverage:
Increase my Monthly Benefit Amount to: $ _____ ❑ Change in Elimination Period: ❑ 90 days

Section 4

The Monthly Benefit Amount herein applied for must be equal to or less than 60% of your Pre-Disability Earnings. ❑ Yes ❑ No

Section 5

PLEASE COMPLETE THE FOLLOWING:

All questions are answered to the best of my knowledge and belief: **YES/NO**

1. During the last 5 years, have you 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 youbeen 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 been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity)? ..... ❑ ❑

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 disqualifies you from acceptance for coverage at this time.

I/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. I/We do not receive temporary or conditional insurance coverage just because I/we submit an application.

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

Section 7

AUTHORIZATION

I/We hereby certify that I/we have read or have had read to me/us 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/our knowledge and belief. I/We understand that any material misrepresentations in this application could cause a claim to be denied under any insurance issued based on this application. I/We 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/We also agree that a copy of this application shall be attached to and form a part of any certificate issued. I/We also understand that the Company may request whatever additional evidence of insurability it needs.

Subject to the deferred effective date provision, I/We understand that coverage will not become effective until the Company grants its underwriting approval. I/We do not receive temporary or conditional insurance coverage just because I/we submit an application and pay the first premium.

I/We 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/our physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status except drug and alcohol treatment information.

Hartford Life and Accident Insurance Company will use the information to decide if and to what extent we are eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I/We understand the Medical Information Bureau, Inc. will release records or information only to Hartford Life and Accident Insurance Company.

I/We authorize Hartford Life and Accident Insurance Company to give information about me/us to: its reinsurer(s), any other insurance company to whom I/we 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/We authorize Hartford Life and Accident Insurance Company, or its reinsurers, to make a brief report of my/our personal health information to Medical Information Bureau.

I/We understand that upon written request I/we 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/our coverage or, if no coverage has been issued one (1) year from the date of this application.
I/We understand that a photocopy of this form is as valid as the original, and that I/we have a right to receive a copy of this form upon request.

I/We certify that I/we have received the Notice of Insurance Information Practices. I/We agree that this document and all its contents shall form a part of my/our enrollment request for group benefits.

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

Section 8

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 9

Member's signature (Sign name in full) _____ Date_____
Required Required

FRAUD WARNING STATEMENT
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

QUESTIONS?
Call: 1-800-459-2851
E-Mail: customerservice.service@mercer.com

PA-9357 (HLA) (NY) (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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Group Disability Income Insurance Plan

DEVELOPED FOR YOUR ASSOCIATION

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

If a covered injury 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 Group Disability Income Insurance Plan sponsored by your association, a portion of your income would continue in the form of a monthly benefit that you select. Don't let a disability rob you of your income. Rely on the protection provided by the Group Disability Income Insurance Plan.

WHO CAN APPLY

All Actively-at-Work (at least 20 hours per week) members under age 60 may apply for this coverage.

This coverage is available only for residents of the United States excluding AK, AR, ME, MD, MN, MS, MO, NH, NM, NC, UT and WA.

HOW THIS PLAN WORKS

Plan pays after a 90-day Elimination Period, to a maximum of two years if you are Totally Disabled due to a covered Injury. If Total Disability occurs at or after age 64, benefits are paid for a maximum of 1 year.

YOU CAN SELECT UP TO $2,000 IN MONTHLY BENEFITS

You select the monthly benefit you wish to receive up to $2,000 per month (in $100 increments). This Monthly Benefit you select should not exceed 60% of your Pre-Disability Earnings.

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 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 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. If you are to become covered under the Policy; or covered for increased benefits under the Policy and you are not Actively-at-Work on the date your coverage is to become effective, you will not be covered until the first day of the month on or next following the date you are Actively-at-Work for 3 months. 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.

Premiums apply at age when insurance becomes effective and at attained age on renewal dates. Rates and/or benefits in this brochure will not be changed unless they are changed for all insureds in your classification.

MONTHLY PREMIUMS PER $100 MONTHLY BENEFIT

Age	Male	Female
Under age 30	$0.17	$0.17
30-34	0.14	0.19
35-39	0.11	0.23
40-44	0.12	0.27
45-49	0.16	0.31
50-54	0.22	0.38
55-59	0.38	0.56
60-64*	0.62	0.81

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.

*For renewal purposes only—only those under age 60 may enroll.

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 any premiums that have been paid will be promptly refunded in full, minus any claims paid.

IMPORTANT DEFINITIONS

Total Disability

Total Disability means disability which during the Elimination Period and the first 24 months during which Accident Total Disability Benefits are payable, wholly and continuously prevents You from performing the Essential Duties of Your Occupation.

Pre-Disability Earnings

a.) If self-employed, Your net income after the deduction of business expenses for the Calendar Year immediately preceding the Total Disability, or

b.) If not self-employed, Your average monthly pay or rate of pay (not counting dividends or overtime payment) for the 12 months immediately preceding the Total Disability.

Actively at Work means You are performing all the Essential Duties of Your Occupation for wage or profit on a full-time basis (at least 20 hours per week).

Elimination Period means the number of consecutive days at the beginning of any one period of Total Disability which must elapse before benefits are payable.

Essential Duty means a duty that: 1) is substantial, not incidental; 2) is fundamental or inherent to the occupation; and 3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty. However, working more than 40 hours per week is not an Essential Duty.

TERMS OF COVERAGE

Exclusions and Limitations

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) war or act of war, whether declared or not, but not including acts of terrorism; or 3) any Injury sustained while riding on, boarding or alighting from, any aircraft: a) as a pilot, crew member or student pilot; b) operated by any military authority (land, sea or air), unless it is a military transport aircraft used for transport and operated by the United States Military Air Mobility Command (AMC) or an AMC type service of a national government recognized by the United States; or c) being used for tests, experimental purposes, stunt flying, racing or endurance tests; 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; or 6) Sickness or disease.

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.

Termination of Coverage

Your coverage will end on the earliest of: 1) the date The Policy terminates; 2) the date Policyholder withdraws its sponsorship of, or cancels, The Policy; 3) the premium due date on or next following the date: a) You cease to be an active member of the Policyholder; or b) You attain the Policy Age Limit; 4) the date You cease to be Actively at Work, except due to disability covered by The Policy as described herein; or 5) the premium due date any required premium contribution is not made, subject to the Individual Grace Period.

Underwritten by:

THE HARTFORD

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.

Administered by:

MERCER

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

Questions?
1-800-459-2851
www.pgainsurance.com

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

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 Professional Golfers' Association.

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.

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.

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.