GROUP TERM LIFE INSURANCE
PERSONAL HEALTH APPLICATION

Hartford Life and Accident Insurance Company
One Hartford Plaza

THE HARTFORD

AFFINITY PROVIDER
ILLINOIS CPA SOCIETY

Association: **Illinois CPA**
P.O. Box 14533
Des Moines, IA 50306

Questions? **Call toll-free: 1-800-842-ICPA (4272)**
Email: customerservice.service@getamba.com

Policyholder (and Participating Organization):	Policy No.:	Certificate No.: (Leave Blank)
Illinois CPA	AGL-1934	

Member's Name (First, Middle Initial, Last)	☐ Male ☐ Female ☐ Other	Height: _____ft. _____ in.	Weight: _____ Lbs. (if currently pregnant, pre-pregnancy weight)
Street:	City:	State:	Zip Code:
Date of Birth:	Place of Birth (State/Country):		Preferred Phone #:
Social Security Number:	Email Address:		
Member Number:	Member's Occupation:		Specialty/Duties:
☐ I am a current ICPAS member.			

Primary Beneficiary(ies) – Print full name and complete address		
Name:	Relationship:	Date of Birth:
Address:		Telephone #:
Social Security Number:		Benefit Percent: %

Contingent Beneficiary(ies) – Print full name and complete address		
Name:	Relationship:	Date of Birth:
Address:		Telephone #:
Social Security Number:		Benefit Percent: %

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Life Form Series includes GBD-1000 A (10/08), GBD-1100 (10/08), or state equivalent.
TL648E2-AGL1934SIMA
54259/54260/1018/52247
7/25

Spouse's Name (First, Middle initial, Last) if applying	☐ Male ☐ Female ☐ Other	Height: _____ft. _____ in.	Weight: _____ Lbs. (if currently pregnant, pre-pregnancy weight)
Street:	City:	State:	Zip Code:
Date of Birth:	Place of Birth: (State/Country)	Preferred Phone #:	
Spouse's Occupation	E-mail:	Social Security Number:	

Primary Beneficiary(ies) – Print full name and complete address		
Name:	Relationship:	Date of Birth:
Address:		Telephone #:
Social Security Number:		Benefit Percent: %

Contingent Beneficiary(ies) – Print full name and complete address		
Name:	Relationship:	Date of Birth:
Address:		Telephone #:
Social Security Number:		Benefit Percent: %

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GROUP TERM LIFE INSURANCE
Amount Desired ($25,000 minimum up to $150,000 maximum in $25,000 increments)

Please indicate if request is for: ❑ New Coverage

Member:
❑$25,000 ❑$50,000 ❑$75,000 ❑$100,000 ❑$125,000 ❑$150,000

Spouse:
❑$25,000 ❑$50,000 ❑$75,000 ❑$100,000 ❑$125,000 ❑$150,000

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

❑Change in Coverage

Member's Current benefit amount: $_____ Additional benefit requested: $_____ Total benefit: $_____

Spouse's Current benefit amount: $_____ Additional benefit requested: $_____ Total benefit: $_____

CHILD COVERAGE

Child Coverage: ❑Yes ❑No

If Child Coverage is desired, please select coverage requested and complete the following:
Age 15 days to 6 months ❑ $500 6 months to age 19 (23 if student) ❑ $5,000

Full Name	Male / Female / Other	Birth Date	Coverage Requested

	MEMBER	SPOUSE
By applying for this insurance, do you intend to replace, discontinue, or change an existing life insurance policy that is not otherwise expiring?	☐ Yes ☐ No	☐ Yes ☐ No
Have you ever been declined for life insurance? If "yes" date and reason for declination:	☐ Yes ☐ No	☐ Yes ☐ No
In the past 12 months, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine products or snuff? If "yes", indicate amount used daily: Member: _____ Spouse: _____	☐ Yes ☐ No	☐ Yes ☐ No
Do you consume alcohol? If "yes", please indicate: Amount: Member: per weekday _____ per weekend _____ Spouse: per weekday _____ per weekend _____	☐ Yes ☐ No	☐ Yes ☐ No

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PLEASE COMPLETE THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:	MEMBER	SPOUSE
1. In the past 5 years, have you been diagnosed or treated for high blood pressure, cancer, tumor, nervous system disorder, diabetes, any heart, blood or circulatory disorder, immune disorder, gastro-intestinal disorder, any disease or disorder of the glands, thyroid, any lung or respiratory disorder, liver, kidney or genitourinary disease or disorder, including hepatitis, alcohol or drug abuse or dependency, epilepsy, mental or nervous disorder, neurological impairment, bone, joint, back, muscle or connective tissue disorder, or Chronic Fatigue Syndrome? If "yes" indicate: Diagnosis by your physician: / Date of diagnosis: Treatment including medication, dosage, date last taken: Has the medical professional treating you for this condition released you from care?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
2. Have you ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS)* as defined below?	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 12 months have you been confined in a hospital, nursing home, sanatorium or similar institution (excluding maternity)?	☐ Yes ☐ No	☐ Yes ☐ No

AIDS, Acquired Immune Deficiency Syndrome* as defined by the Centers for Disease Control and Prevention.

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Please read all items carefully and sign below.

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

Notice

To the best of your knowledge and belief, you are required to notify Hartford Life and Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date coverage is approved.

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, and copies of medical records which you have authorized us to review, and information obtained from MIB, Inc.

Authorization

I, an undersigned applicant, authorize Hartford Life and Accident Insurance Company, together with its affiliates, ("Company") to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

In the event that I cannot be reached via telephone, I authorize a representative of the Company to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that they are calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company by telephone.

☐ Yes, you may leave a message as indicated above. ☐ No, please do not leave a message.

(If not checked, you will not be contacted by phone.)

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize any employer, any health or benefits plan, physician, counselor, medical professional, hospital, clinic or medical facility, laboratory, MIB, Inc., pharmacy or pharmacy benefits manager, motor vehicle violation reporting agency, consumer reporting agency that possesses my protected Personal Health Information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), drug and alcohol use history, other insurance coverage or employment status to furnish such protected health information to the Company or its representative. The Company may only use information disclosed under this Authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

I acknowledge that I am currently a member of the Association and understand I must retain membership to be eligible for this insurance plan.

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I hereby acknowledge that I have read all statements and answers in this application, and in any other application or medical form required by the 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 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 any deferred effective date provision, I understand that coverage will not become effective until (a) the Company grants its underwriting approval; and b) at the time of payment of the first premium, I am living, and my insurability remains the same as that described in the application. I do not receive temporary or conditional insurance coverage just because I submit an application and paid my first premium.

I authorize the Hartford Life and Accident Insurance Company to give information about me or my dependents to any other insurance company to whom I or my dependents may apply for Life and Health Insurance, the MIB, 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 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 have received and read a copy of the Notice of Information Practices.

Member's signature (Sign name in full)	_____ Required Date: _____ Required
Spouse's signature (if applying)	_____ Required Date: _____ Required

PREMIUM PAYMENT

I wish to pay my premiums:	☐ Monthly	☐ Quarterly	☐ Semi-annually	☐ Annually

Automatic Bank Withdrawal (Electronic Funds Transfer):

Name:	Banking Institution:	Routing Number:
Account Number:	☐Checking ☐Savings	

I authorize the Administrator to initiate my regular payment from the bank account provided above. I understand that payment will be processed on or after the due date and will continue to be charged or deducted from my account unless I notify the Administrator otherwise in writing or my coverage ends. I also understand if corrections of the debit are necessary, this may involve an adjustment to my account.

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

Spouse's signature (if applying) _____ Required Date: _____ Required

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For residents of Massachusetts: 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.

Return Completed Form Today to:
ICPAS GROUP INSURANCE PROGRAM
P.O. Box 14533
Des Moines, IA 50306

QUESTIONS?
Call Toll Free:
1-800-842-ICPA (4272)
customerservice.service@getamba.com

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