# Hartford Life and Accident Insurance Company

One Hartford Plaza
Hartford, Connecticut 06155

**GROUP LIFE INSURANCE**
**PERSONAL HEALTH APPLICATION**

**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. | | | |
| Important Note: You must meet all requirements for professional membership in Association to apply for this life insurance coverage. | | | |

| **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-AGL1934UWENY
54259/54260/1018/52247

| **Spouse's Name** (First, Middle initial, Last) if applying | ☐ Male<br>☐ Female<br>☐ Other | Height:<br>_____ft. _____ in. | Weight:<br>_____ Lbs.<br>(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: % |

**Spousal Consent For Community Property States Only:** If you live in a community property state – Arizona, Louisiana, Nevada, New Mexico, Puerto Rico, Washington or Wisconsin –, you may complete the Spousal Consent section, which allows your spouse to waive their rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Member named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of the group term life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Member's Spouse: _____ Date: _____

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**LIFE INSURANCE**

Amount Desired ($25,000 minimum up to $500,000 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 ❑$175,000 ❑$200,000 ❑$225,000 ❑$250,000

❑$275,000 ❑$300,000 ❑$325,000 ❑$350,000 ❑$375,000 ❑$400,000 ❑$425,000 ❑$450,000 ❑$475,000 ❑$500,000

**Spouse:**

❑$25,000 ❑$50,000 ❑$75,000 ❑$100,000 ❑$125,000 ❑$150,000 ❑$175,000 ❑$200,000 ❑$225,000 ❑$250,000

❑$275,000 ❑$300,000 ❑$325,000 ❑$350,000 ❑$375,000 ❑$400,000 ❑$425,000 ❑$450,000 ❑$475,000 ❑$500,000

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:<br>Member: _____ Spouse: _____ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Do you consume alcohol? If "yes", please indicate:<br>Amount:<br>Member: per weekday _____ per weekend _____<br>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. Have you ever been diagnosed or treated for high blood pressure, tumor, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune 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, mental or nervous disorder, neurological impairment, bone, joint, back, muscle or connective tissue disorder, or Chronic Fatigue Syndrome? If "yes", indicate:<br><br>Diagnosis by your physician: / Date of diagnosis:<br>Treatment including medication, dosage, date last taken:<br><br>Has the medical professional treating you for this condition released you from care? | ☐ Yes ☐ No<br><br>☐ Yes ☐ No | ☐ Yes ☐ No<br><br>☐ Yes ☐ No |
| 2. Have you ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC*) or any other Disorder of the Immune System as defined below? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Have you ever been confined in a hospital, nursing home, sanatorium or similar institution (excluding maternity)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Have you ever been diagnosed or treated by a member of the medical profession for cancer? If "yes", indicate:<br><br>Type of cancer diagnosed by your physician: / Date treatment completed: | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. Have you ever been diagnosed or treated by a member of the medical profession for seizures? If "yes", indicate:<br><br>Type of seizure diagnosed by your physician: / Date of diagnosis/onset:<br>Cause of seizures: / Frequency of seizures:<br>Medication, dosage, date last taken: / Date of last seizure: | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. In the past 5 years have you consulted any medical professional, surgeon, psychologist, psychiatrist or other practitioner, other than a family member or yourself if you are a physician, for any reason not previously noted on this application? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 7. Are you currently pregnant?<br><br>Are there any medical complications? _____ | ☐ Yes ☐ No | ☐ Yes ☐ No |

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If you answered “Yes” to any of the above questions, provide the details below to include the condition, diagnosis, number of episodes, duration, severity, date of last symptom, current status, treatment, medications and dosages, test results, any further treatments planned and the medical professional’s and hospital’s name, address and phone number. If additional space is needed, provide additional sheet with details.

| Question Number, Condition, Dates and Details | Name of Family Member | Medical professional’s name, full address and phone number |
|---|---|---|
| | | |
| | | |
| | | |

**AIDS Related Complex (ARC)*** is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. “Disorder of the Immune System” includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave’s Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

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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 psychotherapy notes, 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. I acknowledge that upon my written request, the Company will advise whether or not a consumer report was requested, and if so, the Company will provide the name and address of the consumer reporting agency to whom the request was made. I understand that I may contact the consumer reporting agency and request to inspect and receive a copy of the report. 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).

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

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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 contest the validity of 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.

**Read your certificate carefully.**
**Certain war risks are not covered.**

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

I have read the Important Replacement Notice included with the application.

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

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**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** _____ Date: _____
(Sign name in full) Required Required

**Spouse's signature** _____ Date: _____
(if applying) 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.

AMBA

**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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**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

**DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK**

**IMPORTANT REPLACEMENT NOTICE**

**THIS NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY INSURANCE REGULATION NO. 60**

**It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into a paid-up or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to contemplating a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you to decide whether the replacement is in your best interest.**

**I HAVE READ THE IMPORTANT REPLACEMENT NOTICE THAT ACCOMPANIED THIS APPLICATION**.

**Do you intend to replace, in whole or in part, any existing life insurance or annuity?**
**Yes ____No____**

**Date: _____Signature of Applicant: _____**

**Date: _____Signature of Applicant: _____**

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