Instructions for Completing Policyholder Related Information within the Life and Disability Personal Health Applications for California Residents

---

Purpose

This document explains how to complete the policyholder-related sections of the Personal Health Application(s) for California residents. It outlines which information you (as the policyholder) must provide so that your employee's application is processed in an accurate and timely manner.

Instructions

In addition to this aid, please be sure to read all instructions on Page 1 of the application and the Policyholder's Responsibility section on Page 2.

What you need to complete

The sections are as follows:

Page	Areas of Attention
3	Complete the **Policyholder Information** section found at the top of the page.
4	Complete the **Who Requires an Application** section found at the top of the page.
5	Complete the **Coverage Summary** section in its entirety. This section begins in the middle of the page *Note: Basic Life Coverage amounts are important and must be included for all Applicants requesting additional Life coverage.*

Once you have completed these sections, please forward the entire form and the applicant job aid to your employee.

Contact Information

We are here when you need us. If you have any questions about your application, please contact us at **(800) 523-2233** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

Re: Your personal health application

Dear Applicant,

Thank you for choosing benefits coverage with The Hartford[1]. Enclosed you will find your personal health application.

Completing the personal health application
As you complete the application, please understand that the enrollment elections you made through your employer at the time you enrolled are final and are in no way changed by completing this personal health application. In addition, any beneficiary information on file with your employer will not be updated as a result of any information provided on the enclosed personal health application.

Simply complete the shaded areas on the application, referring to the attached instructions, and submit all pages to the address indicated on the first page of the application. Please note that the questions that are not shaded are not relevant to your benefits coverage and any answers provided to those questions will be disregarded.

What you can expect from us
Once you submit your personal health application, we will process it as quickly as possible. We will promptly notify you and your employer of the status of your application, and will let you know if any additional information is needed. If your applications are approved, your premium will be paid through a payroll deduction administered by your employer. Any premium and payment information provided on the personal health application will not change your payroll deduction.

Supporting you through the process
At The Hartford, we are here when you need us. If you have any questions about your application, please contact us at **(800) 331-7234** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, or email us at medical.uw@hartfordlife.com.

Sincerely,

Medical Underwriting
The Hartford Group Benefits
1-800-331-7234
Medical.uw@hartfordlife.com

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies is Simsbury, CT.

Completing your Life Personal Health Application - for California Residents (Applicant)

Purpose

This document explains how to complete your Personal Health Application. It outlines which information you must provide so that your application is processed in an accurate and timely manner.

Instructions

In addition to this aid, please be sure to read all shaded instructions in the shaded areas of the application, including instructions on Page 1 of the application, and the Applicant's Responsibility section on Page 2.

After completing the application, please submit the application to the address listed on the first page. Please keep a copy of the completed application for your records.

What you need to complete

All shaded areas of the application need to be completed to ensure your application is processed in an accurate and timely manner. The shaded sections are as follows:

Page	Areas of Attention
3	Complete the **Proposed Insured Information** section.
4	Complete the section, **Applicants Requiring Health Evaluation**, found in the middle of the page. *Note: You only need to complete the first table that lists the names of applicants, their relationship to you, their date of birth, height, weight and gender.*
9-10	Complete the shaded health questions in the **Health Information** section. For each question on Page 9, please indicate a *yes* or *no* answer in the box provided to the right of the question. Provide any details for *yes* answers on Page 10. Use a separate piece of paper if needed.
11	• Read the **Notice** at the top of the page. • Complete questions 15-20 by providing a *yes* or *no* answer in the box provided to the right of the question. • Read the **Certification** section. • If you understand and agree with the terms of these sections, please sign and date the bottom of the page in the space provided. *Note: If you are applying for Spouse coverage only, then only the Spouse needs to sign the form.*
12	• Read the **Authorization** and **Fraud Notice** sections. • If you understand and agree with the terms of these sections, please sign and date the bottom of the page in the space provided. *Note: If you are applying for Spouse coverage only, then only the Spouse needs to sign the form.*
13	• Read the **Applicant Authorization** section. • Print your name and date of birth at the top of page where the space is provided. • If you understand and agree with the terms of these sections, please sign and date the bottom of the page in the space provided.

Contact Information

We are here when you need us. If you have any questions about your application, please contact us at **(800) 331-7234** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, or email us at medical.uw@hartfordlife.com.

Save a Copy

Clear Form

Clear Form

INSTRUCTIONS

Instructions

Policyholder's Responsibility

1. Fill out the Policyholder Section completely. Please note an incomplete form will result in a delay in processing your request for insurance. Refer to your Policy and employee records. These records are your property and are not on file with Hartford Life and Accident Insurance Company's Group Medical Underwriting Department.
2. In Section #1 "Who Requires an Application" indicate with a check mark all who are required to provide evidence of good health - employee, spouse or child – and for each, check the reason(s) why. Consult your Policy for all requirements, limitations and exceptions. Employees or spouses signing up beyond their new hire eligibility period will be responsible for costs associated with the underwriting process.
3. In Section #2 "Coverage Summary," complete all coverage amounts for each Applicant. **Basic Life Coverage amounts are important and must be included for all Applicants requesting additional Life coverage.** Consult your employee records to determine current coverage amounts. Please note that Hartford Life and Accident Insurance Company does not have access to employee records for amounts of coverage already in force.
4. After completing the Policyholder section, forward the entire form, including both the Policyholder and Applicant Sections, to the employee to complete for all Applicants that need evidence of insurability.
5. No premiums should be deducted on additional amounts until a final decision regarding coverage is received from Hartford Life and Accident Insurance Company's Group Medical Underwriting Department.

Applicant's Responsibility

1. Make sure your Employer has already completed the Policyholder Section of this form in full.
2. The Policyholder Section clarifies which Applicants need to show evidence of good health and should be listed on this Application. Refer to "Who Requires an Application" in the **Policyholder Section** of the form where a box has been marked for each person who is required to fill out an Application – you (the employee), your spouse or child. Enter the names of these individuals on the Application under "Applicants Requiring Health Evaluation," and fill in the information requested.
3. Answer all questions completely and accurately. Even minor details like height and weight are very important and must be accurate.
4. An Applicant who has not enrolled by the new hire eligibility period (shown in the Policyholder Section #1) will be responsible to pay for the cost of physical exams, medical records or medical tests if they are required during the underwriting process.
5. YOU, THE EMPLOYEE MUST SIGN THIS FORM (even if you yourself are not applying for coverage). Use your full legal signature, and enter the date signed. Your spouse must sign this form ONLY if using this form to apply for coverage. He or she must use a full legal signature, and enter the date signed.
6. **BOTH THE EMPLOYER AND EMPLOYEE SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY WITHIN 30 DAYS OF THE SIGNATURE DATE**.
7. The medical and personal information you complete on this form will be considered "current" for 90 days. Leaving information blank can result in delays or may result in your file being closed.

Coverages underwritten by Hartford Life and Accident Insurance Company
The Hartford is Hartford Financial Services Group, Inc. and its subsidiaries, including the issuing companies of Hartford Life Insurance Company and Hartford Life and Accident Insurance Company.

POLICYHOLDER INFORMATION

Policyholder Section
Personal Health Application

Please print in blue or black ink. Initial any changes. Do Not Erase.

Employer Name: Foothill-De Anza Community College District

Division/Subsidiary Name (If Applicable): _____

Policy No.: 677313

Mailing Address: _____ City: _____ State: _____ Zip: _____

Benefits Contact Person: _____ Telephone Number: _____

Email: _____

Employee Name: _____

Date of Hire: _____ Employee Base Annual Earnings (BAE): $ _____

PROPOSED INSURED INFORMATION

Applicant Section
Personal Health Application

BEFORE MAILING Please print in blue or black ink.
Initial any changes.

- **Answer all the questions and DATE and SIGN this form in all areas indicated.**
- Keep a copy for your records.

Mail the completed Policyholder and Applicant section to:

Hartford Life and Accident Insurance Company
Group Medical Underwriting
P.O. Box 2999 Hartford, CT 06104-2999

Employee's Name (First, Middle Initial, Last): _____

☐ Male ☐ Female

Height: ___ ft. ___ in.

Weight: ____lb.

Social Sec. No.: _____

Mailing Address: Street: _____ City: _____ State: _____ Zip Code: _____

Phone Number (Daytime): _____ Phone Number (Evening): _____

Date of Birth: _____

Occupation: _____

Email: _____

Who requires an Application

Check box for each Applicant who requires evidence of good health with an Application, and specify the reason(s) why:
Check all reasons that apply. Identify any Applicants requiring an Application.

EE Employee	☐ **New Hire** Newly hired employee electing coverage above the Guarantee Issue limit during their initial eligibility period.*	☐ **Opting up to Higher Level of Coverage** Employee electing an increase in life benefit as allowed by the plan.*	☐ **Late Entrant** Employee electing coverage who previously did not elect within past eligibility periods.*
SP Spouse	☐ **Newly Eligible Dependent** Spouse coverage elected for the first time above the Guarantee Issue limit during their initial eligibility period.*	☐ **Opting up to Higher Level of Coverage** Spouse coverage elected for an increase in life benefit.*	☐ **Late Entrant** Spouse coverage not previously elected within past eligibility periods. *
CH Child	☐ **Newly Eligible Dependent** Child coverage elected for the first time above the Guarantee Issue limit the during eligibility period.*	☐ **Opting up to Higher Level of Coverage** Child coverage elected for an increase in life benefit.*	☐ **Late Entrant** Child coverage not previously elected within past eligibility periods.*

*Please refer to your Policy and employee records for coverage amounts, eligibility periods (for Late Entrant determination), Guaranteed Issue limits, exceptions for salary increases and rules for "opting up."

Applicants Requiring Health Evaluation (This is critical information and if left blank there will be a delay in processing)

List below the names of Applicants identified in Policyholder Section 1.

First Name, MI, Last Name	**APPLICANTS**	**HEIGHT (ft/in) required**	**WEIGHT (lbs) required**	**DATE OF BIRTH required**	**GENDER**	
	Employee	ft in	lbs	/ / 19	M	F
	Spouse	ft in	lbs	/ / 19	M	F
	Child	ft in	lbs	/ / 19	M	F

If Dependent Coverage is desired, complete the following:

Full Name	Relationship	Birth Date	Height	Weight

OTHER INSURANCE INFORMATION

Does anyone proposed for coverage have any Life Insurance in force or pending in this or any other company?

☐ Yes ☐ No If yes, give details:

Name	Company	Monthly Benefit	Benefit Period	Waiting Period	To be replaced? Yes	No

Please check "Yes" or "No" on the next line

By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? ☐ Yes ☐ No

COVERAGE REQUESTED

COVERAGE REQUESTED: ☐ New Coverage ☐ Change in Coverage

Monthly Benefit Amount: Payment Period Option: Waiting Period Option:

Is the Monthly Benefit Amount herein applied for equal to or less than [ ] of your Basic Monthly Pay minus any Other Income Benefits?

You: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

Amount Desired [ ]

_____
Proposed Insured

_____
Spouse

Please indicate if request is for ☐ New Coverage

☐ Change in Coverage

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

Coverage Summary For each Applicant, complete all three columns

Life Coverages: Be sure to include any inforce Basic Life coverage as a dollar amount value for all Applicants requesting supplemental life coverage. Refer to employee records for Current Coverage Amounts. For most policies, Life coverage can be calculated as 1,2,3 etc. times salary or in dollar amount increments for increment plans.

Applicants for Life Coverage	**Current Coverage Amount** *(This includes any GI coverage if eligible. This would apply to new hires electing for the first time. If late entrant this amount should be zero.)*	**Additional Amount Applied For** *(This amount reflects only the amount to be medically underwritten)*	**Total Coverage** *(Combined total of the amount currently in force and the amount being underwritten)*
Employee: Suppl. Life or Voluntary Life	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**
Salary multiples for BAE plans	**☐ 0x ☐ 1x ☐ 2x ☐ 3x ☐ 4x ___ x Other multiple**	**☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ___ x Other multiple**	**☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ___ x Other multiple**
Employee: Basic Life	**Required if Basic Coverage offered** **$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**
Salary multiples for BAE plans	**☐ 0x ☐ 1x ☐ 2x ☐ 3x ☐ 4x ___ x Other multiple**	**☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ___ x Other multiple**	**☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ___ x Other multiple**
Spouse: Basic Life	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**
Suppl. Life or Voluntary Life	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**
Child: Basic Life	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**
Suppl. Life or Voluntary Life	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**	**$___, ___ ___ ___, ___ ___ ___**

Questions? Call 1-800-331-7234

The following costs were calculated based on your age as of [ ], your [ ] and [ ] deductions. Your employer gave this information to Hartford Life and Accident Insurance Company, please contact your benefits administrator immediately if it is incorrect.

Voluntary Long Term Disability Insurance

You have the opportunity to enroll in [ ]. LTD insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin [ ]. This plan provides you with income protection to replace up to [ ].

☐ I elect to **enroll** in the Voluntary LTD plan at a monthly cost of [$ *]

☐ I elect to **decline** the Voluntary LTD plan.

*Your cost may change if your salary changes within the benefits plan year.

The following costs were calculated based on your age as of [ ] and [ ]. Your employer gave this information to Hartford Life and Accident Insurance Company, please contact your benefits administrator immediately if it is incorrect.

Voluntary Short Term Disability (STD) Insurance

You have the opportunity to enroll in [ ]. STD insurance helps to replace your income if you are sick or injured and cannot work. This coverage commences on the [ ]. This plan provides you with income protection to replace up to [ ].

☐ I elect to **enroll** in the Voluntary STD plan at a weekly cost of [$ *]

☐ I elect to **decline** the Voluntary STD plan.

*Your cost may change if your salary changes during the plan year.

Supplemental Life Insurance – Employee

You have the opportunity to enroll in [ ]. Your election may be made in increments of [ ]. If you elect an amount that exceeds the lesser of [ ], you will need to provide evidence of good health that is satisfactory to Hartford Life and Accident Insurance Company before the excess benefit can become effective. The guaranteed issue amount may increase as it is subject to the final level of participation in this plan. Monthly costs, based on your age, are shown below.*

Employee Life Amounts*	Monthly Cost*

Employee Life Amounts*	Monthly Cost*

To determine the cost for Supplemental Life coverage in excess of [ ] that you wish to elect. For example, to calculate the cost for [ ].

☐ I elect to **enroll** in the Supplemental Life plan for $_____ at a monthly cost of $_____.*
Employee Life Amount

☐ I elect to **decline** the Supplemental Life plan.

*Note: Benefit reductions begin at age [ ]. If you are or over the age of [ ], the monthly costs shown are calculated based on your reduced benefit amount, not the employee life amount shown. Please see your benefits administrator for further information.

Supplemental Life Insurance – Spouse

If you elect the Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Spouse. [ ]. [ ]. Use the rate chart and calculation line below to determine your Monthly cost for this coverage. Supplemental Spouse rates and premiums are based on the [ ].

Spouse Life Amounts*	Monthly Cost*

Spouse Life Amounts*	Monthly Cost*

☐ I elect to **enroll** in the Supplemental Life plan for $_____ at a monthly cost of $_____.*
Spouse Life Amount

☐ I elect to **decline** the Supplemental Life plan for my Spouse.

*Your cost may change if your age category changes within the benefits plan year.

SPOUSE:

First Name	Last Name	Gender	Date of Marriage	Date of Birth	Benefit Amount

Supplemental Life Insurance - Child(ren)

If you elect the Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) [ ]. You may elect [ ]. Use the calculation line to determine your monthly cost for this coverage.
[ ].

Child Life Amount			
Cost per Child			

☐ I elect to **enroll** my dependent child(ren) in the Supplemental Life plan for $_____ at the monthly cost below.

_____ x _____ = $_____
# of Children | Cost Per Child Above | Your Monthly Cost

☐ I elect to **decline** the Supplemental Life plan for my dependent child(ren).

CHILD:

First Name	Last Name	Gender	Date of Birth	Benefit Amount

BENEFICIARY INFORMATION

Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:

- Mary J. Doe, Wife (not Mrs. John Doe).

Contingent:

- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
Contingent						

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Beneficiary – Print full name & relationship to you
Name_____ Relationship_____
The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

HEALTH INFORMATION

Health Questions
Questions 3-5, 7, 8, 11-13, 15-20 are to be answered by all Applicants listed above.

PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS ON THE NEXT PAGE:

1. Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation during the 90 day period immediately before the date of this application? Employee: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

2. At any time during the past 12 months to the present, has anyone proposed for coverage smoked cigarettes, cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff? Employee: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

3. During the past 5 years have any of the Applicants at any time been treated or consulted a physician for, or told they have a problem with, any of the following:

Chest pain, high blood pressure, elevated cholesterol, heart murmur, abnormal pulse, blood or circulatory or vascular conditions?	
Tumor, leukemia, skin disorders, moles, melanoma, basal cell carcinoma?	
Thyroid, spleen, any disease or disorder of the glands?	
Asthma, bronchitis, pneumonia, respiratory problems, tuberculosis, Avian flu?	
Ulcer, liver, stomach, colitis, rectum, intestines, gallbladder, upper or lower digestive system?	
Kidneys, bladder, or urinary tract - chronic?	
Genital or reproductive organ problems?	
Drug abuse, alcoholism, drug or alcohol or nicotine use on a regular basis – Indicate amount used daily?	
Immune system, lupus, anemia or other blood conditions?	
Any disease or disorder of the brain or nervous system, Parkinson's Disease, Alzheimer's, epilepsy?	

4. During the past 5 years has anyone proposed for coverage been diagnosed with, or had any symptoms due to any of the following conditions or treatments listed below:

Heart-Related Surgery, Heart Attack		Crohn's Disease	
Stroke		Kidney Failure, Dialysis	
Heart Disease, excluding high blood pressure, excluding heart murmur		Hepatitis, excluding Hepatitis A	
Blocked Arteries, arteriosclerosis, atherosclerosis, aneurysm, deep vein blood clot		Diabetes	
Chronic Obstructive Pulmonary Disorder (COPD)		Knee Disorder, Injury or Surgery	
Emphysema		Back or Neck Disorder, Injury or Surgery	
Adjustment Disorder		Joint or Ligament Disorder, Injury or Surgery	
Bipolar Disorder		Osteoporosis, Osteopenia	
Depression (single episode)		Multiple Sclerosis (MS)	
Depression (multiple episodes)		Amyotrophic Lateral Sclerosis (ALS)	
Psychotic Disorders, Personality Disorders		Muscular Dystrophy (MD)	
Other Mental/Nervous/Psychiatric Disorders (including Anxiety)		Arthritis	
Cancer, excluding Basal Cell Carcinoma		Fibromyalgia	
Cirrhosis		Chronic Fatigue Syndrome	
Ulcerative Colitis		Sleep Apnea	

5. Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder?	
6. 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?	

ADDITIONAL QUESTIONS:
During the past 5 years has anyone proposed for coverage:

7. Consulted or been examined by any healthcare provider for anything other than normal physical exams or acute illness such as cold, flu or sore throat?	
8. Had any lab tests, x-ray, electrocardiogram or other diagnostic testing other than those requested as part of routine physical with normal findings?	

9. During the past 5 years has anyone proposed for coverage been hospitalized for any condition?	
10. Has anyone proposed for coverage been confined in a hospital due to illness in the past 5 years?	
11. Is anyone proposed for coverage **currently** pregnant? If yes, Name: What was your pre-pregnancy weight?	
12. Is anyone proposed for coverage taking medication for any condition or disease?	
13. Please list any symptoms, injury, birth defect, congenital defect, disease or other disorder not mentioned above.	

If you answered "Yes" to any of the above questions, please explain the details.

Question Number	Name	Disorder or Reason	Dates To/From	Give details for any "Yes" answer. Explain nature of illness, number of attacks, duration, severity, treatment, names & addresses of physicians, hospitals, & date of full recovery.

Applicant name(s):	Medical condition:	Date of Diagnosis:
Treatment/Medication:	Date treatment started:	Date of last treatment:
Current Status:		Date of last symptom:
Physicians name and complete address:		

Please provide Primary Care Physician's name and complete mailing address:

_____

Simplified Medical Underwriting Questions

14. During the past 5 years have you been treated, diagnosed or received medical advice for a heart attack, stroke, cancer, back, muscle, joint or mental nervous disorders or Acquired Immune Deficiency Syndrome?

Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Please review your answer to this question to be sure that you have answered it fully and truthfully. A misrepresentation on this question could void your coverage. Answering "No" to this question will qualify you for coverage. Answering "Yes" to this question disqualifies you from automatic acceptance for coverage at this time. However, if you feel you have recovered or are no longer requiring medical services, you may ask for reconsideration by completing a Personal Health Application. Please contact your HR department for this form.

Notice: Applicant is required to notify Hartford Life and Accident Insurance Company in writing of any changes in any Applicant's medical condition between the date that Applicant signs this form and the date coverage is approved.

15. During the past 5 years, with the exception of a past pregnancy, has anyone proposed for coverage lost time from work for more than 2 consecutive weeks or 10 work days due to the same physical, mental, or emotional condition, disability, injury or sickness, within a 36 month period?	

During the past 5 years, has anyone proposed for coverage:

16. Used any controlled substances with the exception of those prescribed by his or her physician?	
17. Received medical advice or sought treatment for illegal drug use or alcohol abuse?	
18. Been advised to reduce the consumption of drugs or alcohol?	
19. Been charged with operating a motor vehicle under the influence of drugs or alcohol?	

20. Is anyone proposed for coverage currently undergoing any diagnostic testing for symptoms without a final diagnosis or resolution?	

CERTIFICATION

I hereby certify that all statements and answers contained herein, are full, complete, and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the coverage, within the contestable period if such misrepresentation materially affects acceptance of the risk. This information may be used by the Hartford Life and Accident Insurance Company for plan administration purposes to decide if the person(s) is/are eligible for coverage.

Subject to the deferred effective date provision I understand that coverage will not become effective until Hartford Life and Accident Insurance Company grants it's underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

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

Applicant Confirmation

I have been given the opportunity to enroll in [ ]. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and Accident Insurance Company and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages [ ]. I am not now disabled and I am performing all the duties of my occupation on a full-time basis. My spouse is either actively at work or, if not employed, able to carry on all the normal and customary activities of a person of like age and sex in good health.

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force.

Please print Employee Full Name (First and Last):

Please print Spouse's Full Name (First and Last)

EMPLOYEE' S SIGNATURE **(required)** or Legal representative to Employee

DATE SIGNED

Relationship:

SPOUSE'S SIGNATURE (required only if applying for coverage)

DATE SIGNED

AUTHORIZATION

I understand the Medical Information Bureau, Inc. will release records or information only to the Hartford Life and Accident Insurance Company. I authorize the 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 this authorization. This authorization expires 30 months 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 wish to pay my premiums: ☐ Quarterly ☐ Semi-annually ☐ Annually

I authorize premium deductions from my: ☐ MasterCard ☐ VISA
Cardholder's Name: Card #: Expiration Date:
Bank card payment option is not available in California.

PRE-EXISTING CONDITIONS LIMITATION

I further understand that any condition that is: excluded; or limited by the policy will not be covered under this policy at any time. I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the [ ] period prior to my effective date of coverage will not be covered until I have gone [ ] ending on or after my effective date of coverage without medical advice or treatment for that condition, provided that the condition is not specifically excluded or limited by the policy.

FRAUD NOTICE

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 is guilty of a crime and may be subject to fines and confinement in prison.

This information may be used by the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company (for fully insured coverages) or my employer/administrator (for self-funded coverages) for plan administration purposes to decide if the person(s) is/are eligible for coverage.

EMPLOYEE' S SIGNATURE **(required)** or Legal representative to Employee	DATE SIGNED Relationship:	SPOUSE'S SIGNATURE (required only if applying for coverage)	DATE SIGNED

 # Applicant Authorization (This section is very important. Your form cannot be processed without it.)

Authorization to Disclose Protected Health Information
To Be Used To Determine Eligibility for Group Life and/or Disability Coverage
(Group Life and Disability Income are not subject to the requirements of HIPAA)

_____ ____/____/____
Name of proposed insured (please print) **Date of Birth**

I have applied for insurance under a Group Life and/or Disability Policy issued by Hartford Life Insurance Company and/or Hartford Life and Accident Insurance Company. To assess whether I am eligible for this insurance, these companies may require that I authorize disclosure of a copy of my health information. This authorization is intended to comply with the requirements under §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), effective April 14, 2003.

I **authorize** any: health plan, physician, medical or health practitioner, counselor, therapist, hospital, clinic, other medical or medically-related facility, or other health care provider who has provided treatment, payment, or services to me or on my behalf within the last 10 years; insurance company; or reinsurance company, with which I have had coverage; the Medical Information Bureau, Inc. (MIB), and any consumer reporting agency (collectively, "Releasors"); to disclose to the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company Health Information about me. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company may disclose the Health Information: to their agents; to their employees; and to their representatives (collectively "Hartford"); my entire Health Information. Health Information means the entire medical file. This includes, but is not limited to: x-rays; photocopies of medical records, medical histories, physical, mental or diagnostic examinations and treatment notes, that relate to: 1) Pre-existing or current illnesses, sicknesses, disease, disabilities, disorders, accidents, injuries or any other health conditions, 2) Confinements in hospitals, medical facilities or medical clinics, 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners, 4) Drug use, alcohol use, or mental health information protected by Federal Law, 5) Counseling or therapy. Health information also means information on the diagnosis and treatment of mental illness. But, it excludes psychotherapy notes as defined by HIPAA. I understand that the MIB will only disclose health information to Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Hartford will use this information to underwrite my request for coverage; make eligibility, risk rating, policy issuance and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to any coverage I have applied for with Hartford.

By signing this Authorization, I acknowledge and agree:

- That any agreements I have made to restrict disclosure of my health information do not apply to this Authorization;
- That I am authorizing the Releasors to release and disclose my entire medical file, as described above, without restriction.

By signing this Authorization, I acknowledge that I understand the following:

- That health information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the Releasors' knowledge. Note that Hartford only will use this information to underwrite your request for coverage; make eligibility, risk rating, policy issuance and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to coverage you have applied for with Hartford.
- That if 1) I refuse to sign this Authorization to release my entire medical file; or 2) if this Authorization is altered by me in any way, Hartford may not be able to process my application for coverage.
- That, if 1) Hartford denies my request for coverage; and 2) this denial is based, in whole or in part, on health information obtained in connection with this Authorization; Hartford will not release this information to me unless otherwise authorized by the Releasors, including my physician or other medical professionals, that disclosed such information to Hartford unless required by law.
- That, if necessary, Hartford will send this Authorization to Releasors authorized to release health information about me.
- That Hartford will also provide me with written notice of Releasors to which Hartford sends my Authorization.
- That I have a right, at any time, to revoke this Authorization. To do so, I must send a written request directly to such Releasors. My revocation will not be effective: to the extent that action has been taken in reliance upon this authorization; or, Hartford otherwise has the right: to contest the policy; or a claim under the policy.
- That this Authorization will expire 30 months from the effective date of my coverage or if no coverage has been issued, one (1) year from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original.
- That I am entitled to a signed copy of this Authorization.

_____
Signature of Proposed Insured or Proposed Insured's Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Proposed Insured (Required if signed by Personal Representative.)

NOTICE OF INSURANCE INFORMATION PRACTICES

PLEASE READ AND RETAIN THIS NOTICE OF INSURANCE INFORMATION PRACTICES FOR YOUR RECORDS.

In order to properly underwrite and administer your application for insurance coverage, we must collect certain information concerning your insurability. You are our most important source of information, but we may also contact other sources such as medical professionals and institutions, employers and other insurance companies. While all information regarding your insurability will be treated as confidential, in some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

INVESTIGATIVE CONSUMER REPORTS

As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. You have the right to send a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

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.

ACCESS, CORRECTION AND DISCLOSURE

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Also, please be advised that personal and confidential information collected by us may, in certain circumstances, be disclosed to third parties without authorization. A notice providing further description of the circumstances under which information about you may be disclosed and the types of persons and organizations to whom it may be disclosed will be sent to you upon your written request. If you desire further information or access to your personal information, please send your written request to: Hartford Life Insurance Company or Hartford Life and Accident Insurance Company, 200 Hopmeadow St., Simsbury, CT 06089.

Underwriting Companies: Hartford Life Insurance Company or Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies is Simsbury, CT.