For Members of the Air Force Sergeants Association

GROUP TERM LIFE INSURANCE APPLICATION

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. Return your completed form to:

AFSA Member Insurance Program Administrator
1200 E. Glen Ave.
Peoria Heights, IL 61616-5384

Questions? Call 888.834.9024

SECTION 1

Policyholder's Name:	Policy No.:	Certificate No. (Leave Blank):

SECTION 2

Proposed Insured's Name (First, Middle Initial, Last):	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY):
Height: _ft. _in. Weight: _____lb.	Place of Birth (State/Country):	Phone No. ( )
Street City State ZIP	Email Address: _____	

Beneficiary (print full name & relationship to you):
Name_____ Relationship_____

The proposed insured will be the beneficiary for any dependent coverage desired.

SECTION 3

Spouse's Name (First, Middle Initial, Last), if applying:	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY):
Height: _ft. _in. Weight: ___lb.	Place of Birth (State/Country):	

SECTION 4

Amount Desired (Under age 60: $25,000 minimum up to $500,000 maximum in $25,000 increments; Age 60-69: $25,000 minimum up to $100,000 maximum in $25,000 increments)

Please indicate if request is for:

☐ New Coverage

Spouse $_____ Proposed Insured $_____

The spouse may not be covered under a plan with benefits greater than 100% 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 $: _____

IF REQUEST IS TO CHANGE EXISTING COVERAGE PRINT ONLY ADDITIONAL AMOUNT DESIRED

SECTION 5

If dependent coverage is desired, complete the following (attach sheet of paper if additional space is needed):

Dependent Full Name	Relationship	Birth Date

SECTION 6

PLEASE COMPLETE THE FOLLOWING:	YES	NO
At any time during the past 12 months to the present, have you or your spouse smoked cigarettes or cigars or used a pipe, chewing tobacco, nicotine chewing gum, or snuff?		
In the last 2 years, have you or your spouse been unable to perform the full-time duties of your occupation for 10 consecutive days? If not employed, have you or your spouse been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90-day period immediately preceding the date of this application for 10 consecutive days?		
All questions are answered to the best of my knowledge and belief:		
1 In the past 10 years, has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for: A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood, or circulatory system?		
B. Asthma, shortness of breath, tuberculosis, or any disease or disorder of the lungs or respiratory system or sleep disorder?		
C. Colitis, ulcer, kidney disease or disorder or liver disease or disorder, or any disease or disorder of the digestive, urinary, or reproductive systems?		
D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?		
E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands or thyroid?		
F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?		
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?		

2	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 has anyone proposed for coverage been confined or treated in any hospital, sanatorium, or similar institution?		

SECTION 7

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

Question Number and Condition	Name of Family Member	Dates	For any question answered "yes" please provide details, your physician's name, full address and phone number (required for processing)

(Attach sheet of paper if additional space is needed).

SECTION 8

Please read carefully all items and sign below.

AUTHORIZATION TO OBTAIN, RELEASE, AND DISCLOSE INFORMATION

I hereby certify that I have read all statements and answers in this application and in any other application or medical form required by The Hartford, and that they are full, complete, and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk. I understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. I also agree that a copy of this application shall be attached to, and form a part of, any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs.

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

I authorize any: doctor or counselor; health practitioner; hospital, clinic, or medical facility; insurer or reinsurer; Medical Information Bureau, Inc.; or employer; to give The Hartford or its legal representative information about my or my dependent's physical or mental health, (including history, condition, diagnosis, and treatment), drug or alcohol use history, other insurance coverage except drug and alcohol treatment information.

The Hartford will use the above information to decide if and to what extent I or my dependents are eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford.

I authorize The Hartford to give information about me to any other insurance company to whom I or my dependent may apply for life and health insurance, the Medical Information Bureau, 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 or authorized 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 certify that I have received the Notice of Insurance Information Practices. I agree that this document and all of its contents shall form a part of my enrollment request for group benefits.

Notice: I understand that California law prohibits an HIV test from being required or used by Health Insurance Companies as a condition of obtaining health insurance coverage.

SECTION 9

Member's signature (sign name in full)_____ Date_____

Required Required

Spouse's signature (if applying)_____ Date_____

Required Required

SECTION 10

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?
You: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

Return Completed Form Today to:

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