For Members of the Air Force Sergeants Association

GROUP TERM LIFE INSURANCE APPLICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Hartford, CT 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

Please Print. Use Dark Ink. Do Not Erase. Initial All Changes. For Office Use: h w

SECTION 1			
Policyholder:	Policy No.:	Certificate No. (Leave Blank):	
SECTION 2			
Proposed Insured's Name (First, Middle Initial, Last):	☐ Male ☐ Female	Date of Birth:	Height: __ft. __in. Weight: ___lb.
Street City State ZIP	Preferred Phone No.: ( )	Email Address:	
Proposed Insured's Occupation			
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

$_____ $_____

Proposed Insured Spouse

The spouse may not be covered under a plan with benefits greater than 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 dependent coverage is desired, complete the following:

Full Name	Relationship	Birth Date	Height	Weight

SECTION 5

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

PLEASE COMPLETE THE FOLLOWING:	YES	NO
1. 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, or if not employed, 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?		
2. 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? C. Colitis, ulcer, kidney disease, 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? 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?		
3. 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 have you been confined or treated in any hospital, sanatorium or similar institution?		

SECTION 6

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

Attach sheet of paper if additional space is needed.

SECTION 7

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 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 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 Hartford Life and Accident Insurance Company 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, or employment status.

Hartford Life and Accident Insurance Company 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 Life and Accident Insurance Company.

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 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 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.

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

Spouse's signature (if applying)_____ Date_____

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?

Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

STATE NOTICE

Any person who includes any false or misleading information on an application or filing a claim for an insurance policy is subject to criminal and civil penalties. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, penalties may include imprisonment, fines, denial of insurance, and civil damages.

Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If, while in the state of Florida, a person knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, the person is guilty of a felony in the third degree. 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, misleading or deceptive 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 be subject to substantial civil and/or criminal penalty where and to the extent allowed by state law.

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: _____