AUSA 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. Please return to the Policyholder:
   AUSA Group Benefits Program
   PO Box 9947, Phoenix, AZ 85068

Policy Number: AGL-1978

1 Please complete the following information:

Member Name: (FIRST, MIDDLE INITIAL, LAST)

Gender: ◯ Male ◯ Female Date of Birth: MONTH – DAY – YEAR Height: ft. in. Weight: lbs.

Address: (STREET)

City, State, Zip Code: (CITY) (STATE) (ZIP)

Phone Number: ( ) – Email Address:

Place of Birth: (STATE/COUNTRY)

Beneficiary – Print full name & relationship to you

Name: Relationship:

The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

2 Please complete spouse information (if applying):

Spouse Name: (FIRST, MIDDLE INITIAL, LAST)

Gender: ◯ Male ◯ Female Date of Birth: MONTH – DAY – YEAR Height: ft. in. Weight: lbs.

Place of Birth: (STATE/COUNTRY)

3 Select the amount of coverage desired:

Amount Desired ($160,000 minimum up to $500,000 maximum in $10,000 increments).

Please indicate if request is for ◯ New Coverage Member: $, Spouse: $,

PA-9356 (HLA) (CA)

44193 AU-20698 101075 N44202 B4519 ©2018 AGIA

Please continue on Page 2

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4 Please complete the following:

NO.	QUESTION	MEMBER	SPOUSE
	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?	◯Yes ◯No	◯Yes ◯No
	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?	◯Yes ◯No	◯Yes ◯No
1	**All questions are answered to the best of my knowledge and belief:** 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?	◯Yes ◯No	◯Yes ◯No
	B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system or sleep disorder?	◯Yes ◯No	◯Yes ◯No
	C. Colitis, ulcer, kidney disease or disorder, or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive systems?	◯Yes ◯No	◯Yes ◯No
	D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	◯Yes ◯No	◯Yes ◯No
	E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands or thyroid?	◯Yes ◯No	◯Yes ◯No
	F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?	◯Yes ◯No	◯Yes ◯No
	G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	◯Yes ◯No	◯Yes ◯No
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?	◯Yes ◯No	◯Yes ◯No

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 (MM/DD/YYYY)	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.)

5 Please read carefully all items and sign next page:

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

Please continue on Page 3

5 *(continued)* Please read carefully all items and sign below:

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.

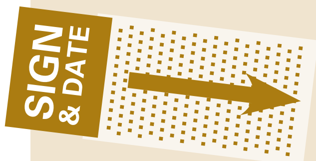
I authorize The Hartford to give information about me to any other insurance company to whom I or my dependent may apply for Life and Health Insurance, the Medical Information Bureau, Inc., or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage 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.



Member signature (Sign name in full) ______ **Date:** __ __ – __ __ – __ __ __ __ (MONTH, DAY, YEAR)

Spouse's signature (Required if applying) ______ **Date:** __ __ – __ __ – __ __ __ __ (MONTH, DAY, YEAR)

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

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Questions? Call Now: 1-800-882-5707

Please Complete Form and Return to:
AUSA Group Benefits Program
PO Box 9947, Phoenix, AZ 85068

Send no money with your application. You will be billed upon approval.

Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

NOTICE OF INSURANCE INFORMATION PRACTICES

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 – NOT APPLICABLE TO RESIDENTS OF NEW YORK

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.

MEDICAL INFORMATION BUREAU (MIB) PRE-NOTICE

Information regarding your insurability will be treated as confidential. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company, with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite Model 400, Braintree, Massachusetts 02184-8734. Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, or their reinsurers, may also release information from their files to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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.

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