Application for Disability Income Insurance
Hartford Life Insurance Company
Hartford, Connecticut

Hartford Life

Please Print. Use Dark Ink. Do Not Erase. Initial All Changes.

Participation Organization **EMERGENCY NURSES ASSOCIATION**	Policy No. AGP 5099, 5098	Certificate No.(Leave Blank)
Applicant's Name (First, Middle Initial, Last)	[ ] Male [ ] Female	Place of Birth: (Town, State)
Street:	State:	Date of Birth:
City:	ZIP:	Age last birthday:
Phone Number (Daytime):	Height:_______ ft ________ in	Weight __________ lbs.
Occupation: Duties: Business Street Address: City: State:	Business Telephone: Zip Code	

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? You: [ ] Yes [ ] No

Does anyone proposed for coverage have any Disability Income 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

COVERAGE REQUESTED: ❑ New Coverage ❑ Change in Coverage	❑ Short Term Disability 1 Year Benefit Period 30 Day Waiting Period	Long Term Disability ❑ 2 Year Plan ❑ 5 Year Plan ❑ To Age 65 Plan	Waiting Period Options: ❑ 60 Days ❑ 90 Days	 ❑ 180 Days ❑ 360 Days
Monthly Benefit Amount: $				

Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Basic Monthly Pay minus any Other Income Benefits? [ ] Yes [ ] No

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? [ ] Yes [ ] No

PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS BELOW:	YES	NO
1 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 system?		
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?		
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 been confined or treated in any hospital, sanitorium or similar institution?		
3 Is anyone proposed for coverage now pregnant? If yes, Name: ________________________ When is the baby due? Are there any medical complications?		

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

Que. No.	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.

Form SRP-1311 AP (A) (HL) (Attach sheet of paper if additional space is needed)

AUTHORIZATION

I hereby certify that I have read or have had read to me 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 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 pay the first premium.

I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; consumer reporting agency; Medical Information Bureau, Inc.; or employer; to give Hartford Life Insurance Company or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, [other insurance coverage] or [employment status].

Hartford Life Insurance Company will use the information to decide if and to what extent I am 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 Insurance Company.

I authorize the Hartford Life 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 the authorization. This authorization expires two (2) years 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 certify that I have received the Notice of Insurance Information Practices and the Investigative Consumer Report Pre-Notification].

[I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until two (2) years after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation.]

I further understand that any condition excluded or limited by the policy or by a Health Waiver attached to my certificate will not be covered under this policy at any time.

Signature of Applicant　　　　　　　　　　Date

I wish to pay my premiums: [ ] Monthly [ ] Quarterly [ ] Semi-annually [ ] Annually

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