

**DISABILITY INCOME INSURANCE APPLICATION**



**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
 Simsbury, Connecticut 06089

**Section 1**

|   |             |                                |
|---|-------------|--------------------------------|
| Association Name: <b>Society of Emergency Medicine Physician Assistants</b> | Policy No.: | Certificate No.: (Leave Blank) |
|---|-------------|--------------------------------|

**Section 2**

|  |                            |  |                                     |                                 |
|--|----------------------------|--|-------------------------------------|---------------------------------|
| Name: (First, Middle Initial, Last)  |                            | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Height: __ft. __in. Weight: ____lb. |                                 |
| Street :   |                            | City:  |                                     | State:                          |
| Date of Birth (MM/DD/YYYY):  |                            | Age Last Birthday:   |                                     | Place of Birth (State/Country): |
| Daytime Phone No.:<br>( )  | Business Telephone:<br>( ) | Email Address: _____   |                                     |                                 |
| Occupation:  |                            | Pre-Disability Earnings: \$ _____                                |                                     |                                 |
| Business Address: Street:  |                            |  |                                     |                                 |
| City:  |                            |  | State:                              | Zip Code:                       |
| 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 |  | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Height: __ft. __in. Weight: ____lb. |                                 |
| Street :  |  | City   |                                     | State:                          |
| Date of Birth (MM/DD/YYYY):                               |  | Age Last Birthday:   |                                     | Place of Birth (State/Country): |
| Spouse's Occupation:                                      |  |  |                                     |                                 |
| Daytime Phone No.: ( )                                    |  | Business Telephone: ( )  |                                     |                                 |
| Pre-Disability Earnings: \$ _____                         |  |  |                                     |                                 |
| Business Address: Street:                                 |  |  |                                     |                                 |
| City:   |  |  |                                     |                                 |
| State:  |  |  | Zip Code:                           |                                 |
| Beneficiary – Print full name & relationship to you       |  |  |                                     |                                 |
| Name: _____ Relationship: _____                           |  |  |                                     |                                 |

**Section 4**

**COVERAGE REQUESTED:**  
 Member Coverage:  
 New Coverage: Monthly Benefit Amount: \$ \_\_\_\_\_  
 Change in Coverage:  
 Increase my Monthly Benefit Amount to: \$ \_\_\_\_\_  
 Change in Waiting Period:  
 Waiting Period:  60 days  90 days  180 days  
 Spouse Coverage:  
 New Coverage: Monthly Benefit Amount: \$ \_\_\_\_\_  
 Change in Coverage:  
 Increase my Monthly Benefit Amount to: \$ \_\_\_\_\_  
 Change in Waiting Period:  
 Waiting Period:  60 days  90 days  180 days

**Section 5**

Do you 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 |
|      |         |                 |                |                |                 |    |
|      |         |                 |                |                |                 |    |
|      |         |                 |                |                |                 |    |

Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 30 hours per week) 90 days before the date of this application? You:  Yes  No Spouse:  Yes  No

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

**Section 6**

|  |   | YES | NO |
|--|---|-----|----|
| All questions are answered to the best of my knowledge and belief: |   |     |    |
| 1  | In the past 10 years, has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for:<br>A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?<br>B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?<br>C. Colitis, ulcer, kidney disease or disorder or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system?<br>D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?<br>E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?<br>F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?<br>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 been confined or treated in any hospital, sanatorium or similar institution?   |     |    |
| 3  | Is anyone proposed for coverage now pregnant?<br>If yes, Name:<br>When is the baby due?<br>What was your pre-pregnancy weight?<br>Are there any medical complications?  |     |    |

**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**

The Hartford® is 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.

**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 Hartford Life and Accident Insurance 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; Medical Information Bureau, Inc.; or employer; to give Hartford Life and Accident 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. Hartford Life and Accident 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 Hartford Life and Accident Insurance Company.

I authorize 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 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. I agree that this document and all of its contents shall form a part of my enrollment request for group benefits.

**PRE-EXISTING CONDITIONS LIMITATION:** 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 one (1) year 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.

**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 10**

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

**SECTION 11**

Member's signature (Sign name in full) \_\_\_\_\_  
Required

Date \_\_\_\_\_  
Required

Spouse's signature (if applying) \_\_\_\_\_  
Required

Date \_\_\_\_\_  
Required

Return Completed Form Today To:



**Questions? Call toll free: (877) 272-1733**