



# Member Application For Term Life Insurance

American Nurses Association/State Nurses Association

Underwritten by: Hartford Life Insurance Company, Simsbury, CT 06089

## PERSONAL INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  Male  Female Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

E-mail: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth: \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Amount Desired: \$\_\_\_\_\_ Please Indicate:  New Coverage  Change in Coverage

Dependent Child Coverage:  Yes  No

If Yes, full name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Beneficiary: Print full name and relationship to you.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

The proposed insured will be the beneficiary for any Dependent Coverage desired.

To be eligible for coverage, you must have been actively engaged in the full-time duties of your occupation, or if not employed, been able to perform the normal activities of a person of like age and sex during the 90-day period immediately before the date of this Application.

At any time during the last 12 months, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum, or snuff?  Yes  No



### 1.

Have you ever had or been treated for a heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system, asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system, colitis, ulcer, kidney disease or disorder of the digestive, urinary or reproductive system, alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disorder of the brain or nervous system, including mental or emotional disorders, cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands, arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?

Yes  No

2.

Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)\*?  Yes  No

\* "AIDS Related Complex (ARC)" is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cells production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

3.

During the past 5 years, have you 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, sanitarium, or similar institution?  Yes  No

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

Question Number	Dates To/From	Give details of nature of illness, duration, severity, names and addresses of physicians, hospitals and date of full recovery.

AUTHORIZATION

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 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 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 Insurance Company.

I authorize the Hartford Life 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.

X \_\_\_\_\_  
Signature and date required to process your application

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## NOTICE OF INSURANCE INFORMATION PRACTICES

Your application is our major source of information. However, The Hartford may also collect or verify information by contacting individuals or organizations that have information or records about you or others to be insured.

Information regarding your insurability will be treated as confidential. Such information will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business. The Hartford or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt from you, the Bureau will arrange disclosure of any information it may have in your file within 15 days. Medical information will be disclosed only to your attending physician. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112; telephone number 1-866-692-6901 (TTY 866-346-3642 for hearing impaired).

The Hartford or its reinsurer(s) may also release information in your file to other insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted.

Upon written request, The Hartford will provide you with information in your file. Medical information will be disclosed only through a physician you designate. Details regarding your right to correct or amend information in your file will be furnished upon written request.

If you would like further details, contact The Hartford, P.O. Box 2999, Hartford, CT 06104-2999, Attn: Group Benefits Department.



# Spouse Application For Term Life Insurance

American Nurses Association/State Nurses Association

Underwritten by: Hartford Life Insurance Company, Simsbury, CT 06089

## PERSONAL INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  Male  Female Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

E-mail: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth: \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Amount Desired: \$\_\_\_\_\_ Please Indicate:  New Coverage  Change in Coverage

Dependent Child Coverage:  Yes  No

If Yes, full name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Beneficiary: Print full name and relationship to you.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

The proposed insured will be the beneficiary for any Dependent Coverage desired.

To be eligible for coverage, you must have been actively engaged in the full-time duties of your occupation, or if not employed, been able to perform the normal activities of a person of like age and sex during the 90-day period immediately before the date of this Application.

At any time during the last 12 months, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum, or snuff?  Yes  No



## 1.

Have you ever had or been treated for a heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system, asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system, colitis, ulcer, kidney disease or disorder of the digestive, urinary or reproductive system, alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disorder of the brain or nervous system, including mental or emotional disorders, cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands, arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?

Yes  No

2.

Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)\*?  Yes  No

\* "AIDS Related Complex (ARC)" is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cells production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

3.

During the past 5 years, have you 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, sanitarium, or similar institution?  Yes  No

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

Question Number	Dates To/From	Give details of nature of illness, duration, severity, names and addresses of physicians, hospitals and date of full recovery.

**AUTHORIZATION**

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 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 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 Insurance Company.

I authorize the Hartford Life 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.

X \_\_\_\_\_  
Signature and date required to process your application

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

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Information regarding your insurability will be treated as confidential. Such information will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business. The Hartford or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt from you, the Bureau will arrange disclosure of any information it may have in your file within 15 days. Medical information will be disclosed only to your attending physician. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112; telephone number 1-866-692-6901 (TTY 866-346-3642 for hearing impaired).

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Upon written request, The Hartford will provide you with information in your file. Medical information will be disclosed only through a physician you designate. Details regarding your right to correct or amend information in your file will be furnished upon written request.

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