



Member Application For Insurance

American Nurses Association/State Nurses Association Disability Income Protection Plan

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



American Nurses Association

Policy Number(s) AGP-5218

Name _____

Address _____

City _____ State _____ Zip _____

Z9WEBD

| | | | | | |
|---------------------------------------------|------------|-------------------------------|----------------------|---------------------------------|--|
| Member's Name (First, Middle Initial, Last) | | <input type="checkbox"/> Male | | <input type="checkbox"/> Female | |
| Address | | Place of Birth (Town, State) | Date of Birth / / | Height _____ ft. _____ in. | |
| City | | State | Zip Code | Weight _____ lbs. | |
| Employer | Occupation | E-mail | | Phone Number () | |
| Duties | | Basic Monthly Pay \$ _____ | | | |

COVERAGE REQUESTED: New Coverage: Monthly Benefit Amount: \$ _____
 Change in Coverage: Increase my Monthly Benefit Amount to: \$ _____
 Payment Period Option _____ Waiting Period Option _____

HEALTH AND OTHER INSURANCE INFORMATION:

1. Do you have any Disability Income Insurance in force or pending in this or any other company? Yes No

| Company | Monthly Benefit | Benefit Period | Waiting Period | To be replaced? |
|---------|-----------------|----------------|----------------|----------------------------------------------------------|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

2. Is the Monthly Benefit Amount applied for equal to or less than 60% of your Basic Monthly Pay less any other Disability Income you may have in Force? Yes No

3. Have you been actively engaged in the full-time duties of your occupation during the 90-day period immediately before the date of this application? Yes No

4. 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?
 You: Yes No
 Spouse: Yes No

PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS BELOW:

5. Have you 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

B. Asthma, shortness of breath, tuberculosis, or any disease or disorder of the lungs or respiratory system? Yes No

C. Colitis, ulcer, kidney disease, or any disease or disorder of the digestive, urinary, or reproductive system? 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

E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands? 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

G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)*? Yes No

6. During the past 5 years, have you consulted any physician, surgeon, psychologist, psychiatrist, or other medical or dental practitioner for anything other than a routine physical, eye examination, or dental examination for any reason not previously noted on this application; or been confined or treated in any hospital, sanatorium, or similar institution? Yes No

7. Are you now pregnant? Yes No
 If "Yes", when is the baby due? _____

Are there any medical complications? 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 cell 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.

If you answered "Yes" to any of the above questions, please explain the details. Explain nature of illness, number of attacks, duration, severity, treatment, names & addresses of physicians, hospitals, & date of full recovery.

| Question Number | Name | Disorder or Reason | Dates To/From | Give details for any "Yes" answer. |
|-----------------|------|--------------------|---------------|------------------------------------|
| | | | | |
| | | | | |

(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.

STATE NOTICE

Any person who includes any false or misleading information on an application 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.



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. The Hartford or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-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 in its file.

Upon receipt 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 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 400, Braintree, Massachusetts 02184-8734.

The Hartford or its reinsurer(s) may also release information from its file 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.

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