GROUP LIFE INSURANCE
PERSONAL HEALTH APPLICATION

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

THE HARTFORD

Association: **Fleet Reserve Association**
P.O. Box 14536
Des Moines, IA 50306

Questions? **CALL: 1-800-424-1120**
EMAIL: fra.service@getamba.com

Policyholder (and Participating Association):	Policy No.:	Certificate No. (Leave Blank):
Fleet Reserve Association	**AGL-1930**	

Member Name (First, Middle Initial, Last):				☐ Male ☐ Female
Date of Birth: _____	Place of Birth (State/Country): _____	Social Security Number: _____	Height: ft._____ in. _____	Weight:_____lbs. (if currently pregnant, pre-pregnancy weight)

Street: _____ City:_____ State:_____ Zip Code: _____	Preferred Phone Number: _____	Email Address: _____

Member Occupation: _____

☐ I am a current FRA Member. Member Number:_____

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

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Primary Beneficiary(ies) – Print full name and complete address

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( )_____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____%

Contingent Beneficiary(ies) – Print full name and complete address

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( )_____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____%

Spouse Name (First, Middle Initial, Last) if applying:				☐ Male ☐ Female
Date of Birth: _____	Place of Birth (State/Country): _____	Social Security Number: _____	Height: ft._____ in._____	Weight: _____lbs. (if currently pregnant, pre-pregnancy weight)

Street: _____ City: _____ State:_____ Zip Code:_____	Preferred Phone Number: _____	Email Address: _____
Spouse Occupation: _____		

Primary Beneficiary(ies) – Print full name and complete address

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( )_____

Social Security Number:_____ Relationship:_____ Benefit Percent: _____%

Contingent Beneficiary(ies) – Print full name and complete address

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( )_____

Social Security Number: _____ Relationship: _____ Benefit Percent:_____%

Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, Louisiana, Nevada, New Mexico or Wisconsin –, you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Member named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of the group term life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Member's Spouse: _____ Date: _____

LIFE INSURANCE

Amount Desired ($25,000 minimum up to $150,000 maximum in $25,000 increments)

Please indicate if request is for: ❑ New Coverage

Member:

❑$25,000 (_0H1) ❑$50,000 (_0N1) ❑$75,000 (_0T1) ❑$100,000 (_0Y1) ❑$125,000 (_YH1) ❑$150,000 (_YN1)

Spouse:

❑$25,000 (_0H5) ❑$50,000 (_0N5) ❑$75,000 (_0T5) ❑$100,000 (_0Y5) ❑$125,000 (_YH5) ❑$150,000 (_YN5)

The Spouse may not be covered under a Plan with benefits greater than 100 percent of the Member's Plan.

❑ Change in Coverage

Member Current benefit amount: $_____ Additional benefit requested: $_____ Total benefit: $_____

Spouse Current benefit amount: $_____ Additional benefit requested: $_____ Total benefit: $_____

Child Coverage: ❑Yes ❑No

If Child Coverage is desired, please select coverage requested and complete the following:

❑ $10,000 (N0E7)

Full Name	Male/ Female	Birth Date

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	MEMBER	SPOUSE
By applying for this insurance, do you intend to replace, discontinue, or change an existing life insurance policy that is not otherwise expiring?	☐ Yes ☐ No	☐ Yes ☐ No
Have you ever been declined for life insurance? If "yes" date and reason for declination: _____	☐ Yes ☐ No	☐ Yes ☐ No
In the past 12 months, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine products or snuff? If "yes", indicate amount used daily: Member:_____ Spouse:_____	☐ Yes ☐ No	☐ Yes ☐ No
Do you consume alcohol? If "yes", please indicate: Member: Amount: per weekday_____ per weekend _____ Spouse: Amount: per weekday_____ per weekend _____	☐ Yes ☐ No	☐ Yes ☐ No

PLEASE COMPLETE THE FOLLOWING:	MEMBER	SPOUSE
1. In the past 5 years have you been diagnosed or treated for high blood pressure, cancer, tumor, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any disease or disorder of the glands, thyroid, any lung or respiratory disorder, liver, kidney or genitourinary disease or disorder, including hepatitis, alcohol or drug abuse or dependency, epilepsy, mental or nervous disorder, neurological impairment, bone, joint, back, muscle or connective tissue disorder, or Chronic Fatigue Syndrome (EXCEPT FOR HIV)? If "yes", indicate: Diagnosis by your physician: _____ Date of diagnosis:_____ Treatment including medication, dosage, date last taken: _____ Has the medical professional treating you for this condition released you from care?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
2. Have you ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC*) or any other Disorder of the Immune System as defined below?	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 12 months have you been confined in a hospital, nursing home, sanatorium or similar institution (excluding maternity)?	☐ Yes ☐ No	☐ 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.

Please read all items carefully and sign below.

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

Notice

To the best of your knowledge, you are required to notify Hartford Life and Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date coverage is approved.

This authorization excludes disclosure of the result of a test for HIV if the applicant has not developed symptoms of the disease AIDS or ARC. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS or ARC.

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, and copies of medical records which you have authorized us to review, and information obtained from MIB, Inc.

Authorization

I, an undersigned applicant, authorize Hartford Life and Accident Insurance Company, together with its affiliates, ("Company") to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

In the event that I cannot be reached via telephone, I authorize a representative of the Company to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that he or she is calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company by telephone.

☐ Yes, you may leave a message as indicated above. ☐ No, please do not leave a message.

(If not checked, you will not be contacted by phone.)

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize any employer, any health or benefits plan, physician, counselor, medical professional, hospital, clinic or medical facility, laboratory, MIB, Inc., pharmacy or pharmacy benefits manager, motor vehicle violation reporting agency, consumer reporting agency that possesses my protected Personal Health Information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), drug and alcohol use history, other insurance coverage or employment status to furnish such protected health information to the Company or its representative. The Company may only use information disclosed under this Authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

I acknowledge that I am currently a member of FRA and understand I must retain membership to be eligible for this insurance plan.

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize any employer, any health or benefits plan, physician, counselor, medical professional, hospital, clinic or medical facility, laboratory, MIB, Inc., pharmacy or pharmacy benefits manager, motor vehicle violation reporting agency, consumer reporting agency that possesses my protected Personal Health Information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), drug and alcohol use history, other insurance coverage to furnish such protected health information to the Company or its representative. The Company may only use information disclosed under this Authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

Subject to any deferred effective date provision, I understand that coverage will not become effective until (a) the Company grants its underwriting approval; and b) at the time of payment of the first premium, I am living, and my insurability remains the same as that described in the application. I do not receive temporary or conditional insurance coverage just because I submit an application and paid my first premium.

I authorize the Hartford Life and Accident 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 MIB, 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. Revocation of this authorization may be the basis for denying insurance benefits. 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 or a person authorized to act on my behalf have a right to receive a copy of this form upon request.

Member signature (Sign name in full) _____ Date _____
Required Required

Spouse signature (if applying) _____ Date _____
Required Required

PREMIUM PAYMENT

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

Automatic Bank Withdrawal (Electronic Funds Transfer):

Name:_____ Banking Institution:_____

Routing Number:_____ Account Number:_____

Bank Account Type: ☐ Checking ☐ Savings

I authorize the Administrator to initiate my regular payment from the bank account provided above. I understand that payment will be processed on or after the due date and will continue to be charged or deducted from my account unless I notify the Administrator otherwise in writing or my coverage ends. I also understand if corrections of the debit are necessary, this may involve an adjustment to my account.

Member signature (Sign name in full) _____ Date _____
Required Required

Spouse signature (if applying) _____ Date _____
Required Required

For residents of Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

Return Completed Form Today to:
FRA-ENDORSED INSURANCE PROGRAMS
P.O. Box 14536, Des Moines, IA 50306

QUESTIONS?
CALL: 1-800-424-1120
EMAIL: fra.service@getamba.com
WEBSITE: www.frainsure.com

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