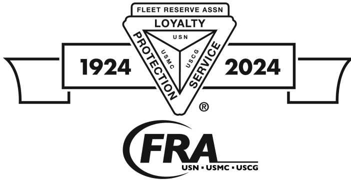
GROUP LIFE INSURANCE
PERSONAL HEALTH APPLICATION

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



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

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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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: ________%

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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 TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:	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? If "yes", indicate: Diagnosis by your physician: _______________ Date of diagnosis:_______________ Treatment including medication, dosage, date last taken: _______________	☐ Yes ☐ No	☐ Yes ☐ No
Has the medical professional treating you for this condition released you from care?	☐ 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.

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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.

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 psychotherapy notes, 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. I acknowledge that upon my written request, the Company will advise whether or not a consumer report was requested, and if so, the Company will provide the name and address of the consumer reporting agency to whom the request was made. I understand that I may contact the consumer reporting agency and request to inspect and receive a copy of the report. 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 and that I meet all requirements for professional membership in FRA.

I hereby acknowledge 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 contest the validity of 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 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. 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.

Member signature (Sign name in full)________________________________ Date ______________________
Required Required

Spouse signature (if applying) ______________________________________ Date______________________
Required Required

Read your certificate carefully.
Certain war risks are not covered. Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

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

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Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

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

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HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK

IMPORTANT REPLACEMENT NOTICE

THIS NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY INSURANCE REGULATION NO. 60

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into a paid-up or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to contemplating a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you to decide whether the replacement is in your best interest.

I HAVE READ THE IMPORTANT REPLACEMENT NOTICE THAT ACCOMPANIED THIS APPLICATION.

Do you intend to replace, in whole or in part, any existing life insurance or annuity?
Yes_____No______

Date: __________________Signature of Applicant: ___________________________________

Date: __________________Signature of Applicant: ___________________________________

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BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plan. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact the company's representative or your own legal advisor.

A beneficiary designation may be changed at any time upon written request.

Please note that a Power of Attorney (POA) may not have the authority to change a beneficiary.

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Doe	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Insured/Member) and dated.**

BEFORE BENEFICIARY DESIGNATION