

**PET Sponsored  
Application for Group Life Insurance**

Hartford Life and Accident Insurance Company

**Use this form when applying for  
Under \$100,000 of Coverage  
Simplified Issue – Only 4 Health Questions!**

Policyholder Name: Professional Educators of  
Tennessee  
Group Policy Number AGL-1701

Member's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

**PRIMARY INSURED** (Indicated above)

Date of Birth: \_\_\_\_\_  Male  Female  
Place of Birth: \_\_\_\_\_  
Height : \_\_\_\_\_ Weight \_\_\_\_\_  
Phone Number: ( ) \_\_\_\_\_

**SPOUSE** (if applying)

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  Male  Female  
Place of Birth: \_\_\_\_\_  
Height : \_\_\_\_\_ Weight \_\_\_\_\_

At any time during the past 12 months to the present,  
has anyone proposed for coverage smoked cigarettes  
or cigars, or used a pipe, chewing tobacco, nicotine  
chewing gum or snuff?

Member  Yes  No  
Spouse  Yes  No

(√) Check the desired amount of Coverage:  
Member:

\$25,000  \$50,000  
Spouse:  
 \$25,000  \$50,000

Member's Beneficiary – Print Full Name and relationship to you

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
The primary insured will be the beneficiary for any Spouse coverage issued

By applying for this insurance, do you intend to replace, discontinue, or  
change an existing policy of life insurance? Member  Yes  No  
Spouse  Yes  No

FORM PA-9199 (1701) (HLA/HL)(SI-Life Q2)

PLEASE COMPLETE THE FOLLOWING:

- 1) During the last 5 years, have you or your spouse been diagnosed or  
been treated for a heart condition, diabetes, kidney or liver disorder,  
lung or respiratory disease, neurological impairment, blood or  
circulatory disorder (including high blood pressure), alcohol or drug  
abuse, cancer, or enlarged lymph glands?  
Primary Insured  Yes  No Spouse  Yes  No
- 2) Have you or your spouse ever been diagnosed or been treated for  
Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related  
Complex (ARC)\* or any other immune deficiency disorder (see  
reverse for complete definition)?  
Primary Insured  Yes  No Spouse  Yes  No
- 3) Have you or your spouse been confined in a hospital, nursing  
home, sanitarium or similar institution in the last 6 months  
(excluding maternity)?  
Primary Insured  Yes  No Spouse  Yes  No

Please review your answers to these questions to be sure that you have  
answered them fully and truthfully. A misrepresentation on these  
questions could void your coverage. Answering "Yes" to any of these  
questions disqualifies you from acceptance for coverage at this time.

I/we understand that coverage will become effective only after approval  
by the Company and receipt of the first payment of premium. By  
signing this application, I/we acknowledge that the Application is true  
and accurate for each person to be insured.

By signing below, I/we acknowledge that I/we have read and agree to  
all terms on the reverse of this form.

x \_\_\_\_\_ Date \_\_\_\_\_  
Signature required to activate coverage

x \_\_\_\_\_ Date \_\_\_\_\_  
Spouse Signature, if applying

*Signature and date required to process your application.*



