


<b>PET Sponsored Term Life Insurance Application</b>  Underwritten By Hartford Life and Accident Insurance Company Simsbury, CT 06089		<b>Use this Application When Applying For More Than \$100,000 of Coverage</b>			
Please Print	Use Dark Ink	Do not erase	Initial All Changes	For office use: h    w	
Policy Holder The Professional Educators of Tennessee			Policy Number AGL-1687	Certificate No. (leave blank)	
Proposed Insured Name (First, Middle Initial, Last)					
<input type="checkbox"/> Male  <input type="checkbox"/> Female		Date of Birth:		Height: ___ ft. ___ in. Weight: _____ lbs.	
Address: (Street, City, State, Zip)			Phone:		
Proposed Insured's Occupation:					
Beneficiary - Print full name & relationship to you					
Name: _____ Relationship: _____					
The proposed Insured will be the beneficiary for any Dependent Coverage desired.					
Amount Desired (\$100,000 minimum up to \$500,000 maximum in \$5,000 increments for Primary Insured; \$100,000 minimum up to \$250,000 in \$5,000 increments for Spouse)					
_____		Please indicate if request is for		<input type="checkbox"/> New Coverage <input type="checkbox"/> Change in Coverage	
Proposed Insured					
_____		The Spouse may not be covered under a Plan with benefits greater than the Member's Plan			
Spouse					
If Dependent Coverage is desired, complete the following:					
Full Name		Relationship	Birth Date	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? <b>Member:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Spouse:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
PLEASE COMPLETE THE FOLLOWING:					
1. In the last 2 years, have you or your Spouse been unable to perform the full-time duties of your occupation for 10 consecutive days, or if not employed, been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90 day period immediately preceding the date of this application for 10 consecutive days?				YES	NO
2. In the past 10 years, has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for: <ol style="list-style-type: none"> <li>1. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?</li> <li>2. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?</li> </ol>					

3. Colitis, ulcer, kidney disease or any disease or disorder of the digestive, urinary or reproductive systems?		
4. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?		
5. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?		
6. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?		
7. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder?		

3. During the past 5 years has anyone proposed for coverage 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, sanatorium or similar institution?

If you answered "Yes" to question 2 or 3, please explain the details on the reverse.

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

Question Number	Name of Family Member	Dates: To/From	Give details for any Yes answer. Give details of nature of illness, number of attacks, duration, severity, treatment, names and addresses of physicians, hospitals, and date of full recovery.

(Attach sheet of paper if additional space is needed).

Please read carefully all items and sign below.

**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION**

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 and Accident 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 and Accident 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 and Accident Insurance

Company. 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 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.

Member's signature (Sign name in full) \_\_\_\_\_ Date \_\_\_\_\_

Spouse's signature (if applying) \_\_\_\_\_ Date \_\_\_\_\_

*Signature and date required to process your application.*

**Please check "Yes" or "No" on the next line.**

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

**STATE NOTICE**

Any person who includes any false or misleading information on an application or filing a claim 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

Please keep this page

Please print this application form and mail the completed application to:

**NEBCO**  
**8500 Freeport Parkway South**  
**Ste. 450**  
**Irving, TX 75063**

You will be billed for the premium upon acceptance of this application

If you have questions or need assistance, please call NEBCO at 1-800-759-0101.

A customer service representative will assist you.

**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](http://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.