

**PET Sponsored**  
**Application for Group Life Insurance**  
 Underwritten By  
 Hartford Life and Accident Insurance Company  
 Simsbury, CT 06089

**Use this form when applying for**  
**Under \$100,000 of Coverage**  
*Simplified Issue - Only 3 health Questions.*

Policyholder Name: The 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

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

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

*Signature and date required to process you application*

## **CERTIFICATION and AUTHORIZATION**

I hereby certify that I have read all statements and answers in this application and that they are full, complete and true to the best of my knowledge and belief. I understand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the coverage, within the contestable period if such misrepresentation materially affects acceptance of the risk. I understand that coverage will not become effective until The Hartford<sup>1</sup> grants its underwriting approval. I agree that subject to the deferred effective date provision that no insurance coverage shall become effective unless: a) The Hartford 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 pay the first premium. I certify that I have received the Notice of Insurance Information Practices.

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 The Hartford 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. The Hartford 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. I authorize The Hartford 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.

1 The Hartford<sup>®</sup> is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. The issuing company is shown on the face page of this application.

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 erythematosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

FORM PA-9199 (701) (HLA)(SI-Life Q2)

### **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 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.**