Union Plus Term-To-70 Life Insurance

Send no money now. Just complete and return this application in the enclosed postage-paid envelope to:
Union Plus Insurance Programs, P.O. Box 47060, Phoenix, AZ 85068-9963

THE HARTFORD

GROUP LIFE INSURANCE APPLICATION
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, CT 06155

Policyholder Name: AFL-CIO Mutual Benefit Fund	Policy No.: AGL-1660	Certificate No. (Leave Blank)

PRIMARY INSURED MEMBER NAME
Name: _____
Address: _____
Address: _____
City:_____ ST: _____ Zip: _____
Union: _____

Date of Birth (MM/DD/YYYY): _____
☐ Male ☐ Female
Place of Birth (city/state/country): _____
Height: _____ft._____in. Weight: _____ lb.

Preferred Phone Number: (_____)_____

Proposed Insured's Occupation:_____

Beneficiary - Print full name & relationship to you
Name:_____ Relationship: _____

Spouse's Name: (First, Middle Initial, Last), if applying
_____
Beneficiary - Print Full Name & relationship to you
Name: _____
Relationship: _____

Date of Birth (MM/DD/YYYY): _____
☐ Male ☐ Female
Place of Birth (city/state/country): _____
Height: _____ft._____in. Weight: _____ lb.

Amount Desired:

Please select: Proposed Insured ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000

Spouse ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000

	Member		Spouse	
PLEASE COMPLETE THE FOLLOWING:	Yes	No	Yes	No
At any time during the past 12 months to the present, have you or your Spouse smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff?				

		Member		Spouse	
	All questions are answered to the best of my knowledge and belief:	Yes	No	Yes	No
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 but excluding HIV), alcohol or drug abuse, cancer, or enlarged lymph glands?				
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, excluding HIV tests?				
3	Have you or your spouse been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity)?				

Form PA-9356 (HLA) (NY)

☐ **Please email me Union Plus benefits updates and consumer tips.**
My email address is: _____

Union Plus Term Life Insurance APPLICATION (continued)

Please read carefully all items and sign below.

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

I/We hereby certify that I/we have read all statements and answers in this application, and in any other application or medical form required by Hartford Life and Accident Insurance Company, and that they are full, complete, and true to the best of my/our knowledge and belief. I/We understand that any material misrepresentations in this application could cause a claim to be denied under any insurance issued based on this application. I/We also agree that a copy of this application shall be attached to and form a part of any certificate issued. I/we also understand that the Company may request whatever additional evidence of insurability it needs.

I/we understand that coverage will not become effective until the Company grants its underwriting approval. I/We do not receive temporary or conditional insurance coverage just because I/we submit an application and paid my first premium.

I/We 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/our physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status except drug and alcohol treatment information.

Hartford Life and Accident Insurance Company will use the above information to decide if and to what extent I/we are eligible for insurance coverage or benefits under the Policy. This information will be treated as confidential. I/We understand the Medical Information Bureau, Inc. will release records or information only to Hartford Life and Accident Insurance Company.

I/We authorize Hartford Life and Accident Insurance Company to give information about me/us to any other insurance company to whom I/we may apply for Life and 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 or authorized by law.

I/We authorize Hartford Life and Accident Insurance Company, or its reinsurers, to make a brief report of my/our personal health information to Medical Information Bureau.

I/We understand that upon written request I/we 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/our coverage or my/our dependent's coverage or, if no coverage has been issued one (1) year from the date of this application.

I/We understand that a photocopy of this form is as valid as the original, and that I/we have a right to receive a copy of this form upon request.

I/We certify that I/we have received the Notice of Insurance Information Practices. I/We agree that this document and all of its contents shall form a part of my/our enrollment request for group benefits.

Proposed Insured's signature (Sign name in full) _____ Date _____
Required Required

Spouse's signature (if applying) _____ Date _____
Required Required

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?

You: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

Form PA-9356 (HLA) (NY)

THE HARTFORD

Underwritten by:
Hartford Life and Accident
Insurance Company
Hartford, CT 06155

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: _____