



## Instructions

### Instructions for electing Group Basic Life Coverage and Basic Dependent Life Coverage only:

1. Please complete the form labeled: Beneficiary Designation
2. Complete beneficiary information for both the primary and contingent beneficiaries for your Basic Life coverage.
3. Return the completed beneficiary designation form to your benefits administrator.

### Instructions for electing Supplemental Life Coverage:

1. Please complete the form labeled: **“Supplemental Life Insurance Enrollment Form”**.
2. If you are a New Hire and electing coverage below the Guaranteed Issue amount of Supplemental Life Insurance coverage, please complete pages 2 and 3 only.  
*Note: A New Hire is a newly hired employee electing coverage for the first time within the initial eligibility period, usually the first 31 days from date of hire.*
3. If you are a New Hire and electing Supplemental Life Insurance coverage above the Guaranteed Issue, please complete this entire application as your plan requires that you provide Evidence of Insurability.
4. If you are not a New Hire and electing Supplemental Life Insurance coverage for the first time, or electing to increase your current coverage, please complete this entire application as your plan requires that you provide Evidence of Insurability.
5. If you elect to increase Supplemental Life Insurance for your Spouse for any amount, Evidence of Insurability will be required.
6. Answer all questions completely and accurately. Even details like height and weight are very important and must be accurate. **Leaving information blank will result in delays or may result in your file being closed.**
7. **YOU, THE EMPLOYEE, MUST SIGN AND DATE THIS FORM** (even if the application is only for your spouse). Use your full legal signature. Your spouse must sign and date this form **ONLY** if he/she is applying for coverage. He or she must use a full legal signature.
8. Return pages 2 and 3 to your benefits administrator to copy and maintain a record of the Supplemental Life Insurance Enrollment form for your benefit file.
9. Send the completed full application (pages 2 through 8) to the following address:

The Hartford Group Benefits  
Attn: SB - List Bill Maintenance Team  
7400 College Blvd, 6th floor  
Overland Park, KS 66210

**THIS FORM MUST BE COMPLETED AND RECEIVED BY THE HARTFORD GROUP BENEFITS WITHIN 30 DAYS OF THE SIGNATURE DATE.**

# Uintah School District Supplemental Life Insurance Enrollment Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Employer Name: Uintah School District		Policy Number: 221441
Street Address: 635 West 200 South		
City: Vernal	State: UT	Zip: 84078
Please check all that apply:      New Enrollment: <input type="checkbox"/> Over GI: <input type="checkbox"/> <input type="checkbox"/> Change:		
Employee First Name:	MI:	Last Name:
Street Address:		
City:	State:	Zip Code:
Day Time Phone:	Evening Phone:	
Social Security Number:	Date of Birth:	Email Address:
Occupation:	Date of Hire:	Annual Salary: \$
Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		

## ***Supplemental Life Insurance - Employee***

You have the opportunity to enroll in Uintah School District's Supplemental Life Insurance plan. Your election may be made in increments of \$5,000, (minimum election of \$20,000), not to exceed \$500,000. If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of \$100,000, you will need to provide evidence of good health that is satisfactory to Hartford Life before the excess can become effective. If you were previously eligible, and are now electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of good health that is satisfactory to Hartford Life before any additional coverage can become effective.

- I elect to **enroll** in the Supplemental Life plan for \$\_\_\_\_\_.  
Employee Life Amount
- I elect to **continue** my current coverage.
- I elect to **decline** the Supplemental Life plan.

\*Note: Benefits reduce beginning at age 65. Please see your benefits administrator for further information.

## ***Supplemental Life Insurance - Spouse***

**If you elect the Supplemental Life plan for yourself**, you may elect Supplemental Life coverage for your Spouse. Your election may be made in increments of \$5,000, (minimum election of \$10,000), to a maximum of \$250,000 but may not exceed 100% of your Supplemental Life amount. Supplemental Spouse rates and premiums are based on the Spouse's age.

- I elect to **enroll** my Spouse in the Supplemental Life plan for \$\_\_\_\_\_.  
Spouse Life Amount
- I elect to **continue** my Spouse's current coverage.
- I elect to **decline** the Supplemental Life plan for my Spouse.

Spouse First Name:	Last Name:
Date of Marriage:	Date of Birth:
Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee First Name: \_\_\_\_\_ Last Name \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Supplemental Life Insurance - Child(ren)**

If you elect the Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) if they are unmarried and under the age of 26. Your election may be in the amount of \$5,000 or \$10,000.

- I elect to **enroll** my dependent child(ren) in the Supplemental Life plan for \$ \_\_\_\_\_.
- I elect to **continue** coverage for my Dependent Child(ren).
- I elect to **decline** the Supplemental Life plan for my dependent child(ren).

**CHILD:**

First Name	Last Name	Gender	Date of Birth

**Beneficiary Designation**

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:

- Mary J. Doe, Wife (not Mrs. John Doe).

Contingent:

- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
Contingent						

**Beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.**

**Employee Confirmation**

I have been given the opportunity to enroll in Uintah School District's Supplemental Life Insurance plans. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and understand my request for coverage may be denied.

I understand that coverages available to me are in accordance with the provisions of the contract between The Hartford and Uintah School District, and that I will not be insured for coverages not included in that contract.

I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis. I am not now disabled and I am performing all the duties of my occupation on a full-time basis.

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Employee First Name: \_\_\_\_\_ Last Name \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer Name: Uintah School District

Policy Number: 221441

**PERSONAL HEALTH APPLICATION**  
**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

1. Applicants Required to Provide Evidence of Insurability (**This is critical information and if left blank will cause a delay in processing your insurance request**).

First Name, MI, Last Name	Applicant(s)	Height (ft/in) Required	Weight (lbs) Required	Date of Birth Required	Gender
_____	Employee	____ ft. ____ in.	_____ lbs.	___ / ___ / ___	<input type="checkbox"/> M <input type="checkbox"/> F
_____	Spouse	____ ft. ____ in.	_____ lbs.	___ / ___ / ___	<input type="checkbox"/> M <input type="checkbox"/> F

2. Health Questions (Questions 1-24 are to be answered by all Applicants listed above.) **Residents of:** Florida, Indiana, Maine, Minnesota, North Carolina, Vermont, and Wisconsin, please see Variable Question Language on page 8 of the application for amended or added language to the below questions. After you have read that information, answer the questions below.

**For questions 1-6, during the past 10 years have any of the Applicants: (Residents of: Indiana, Kansas, Maryland, and Minnesota, please provide medical history during the past 5 years.)**

	EE		SP	
1. Had any surgery or been told to have surgery?	Y	N	Y	N
2. Been in a hospital or other institution for diagnosis or treatment?	Y	N	Y	N
3. Had any injuries from a car accident or filed a Workers' Compensation Claim?	Y	N	Y	N
4. Been declined for any life or disability insurance coverage?	Y	N	Y	N
5. Consulted or been examined by any healthcare provider for anything <b>other than</b> a routine physical with normal findings or acute illness such as a cold, flu, or sore throat?	Y	N	Y	N
6. Had any lab tests, X-ray, electrocardiogram or other diagnostic testing <b>other than</b> those requested as part of a routine physical with normal findings?	Y	N	Y	N

**\*\*\*For each "YES" answer, identify the question number, Applicant name and provide details on pg. 4 through 6 Attach additional paper if necessary.\*\*\***

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and <b>complete address</b> :		

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and <b>complete address</b> :		

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
Physician's name and <b>complete address</b> :		

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 APPLICANT AUTHORIZATION: THIS SECTION IS VERY IMPORTANT. YOUR REQUEST CANNOT BE PROCESSED WITHOUT IT.

**For questions 7-24, during the past 10 years have any of the Applicants at any time been treated or told they have a problem with any of the following: (Residents of: Indiana and Maryland, please provide medical history during the past 5 years.)**

	EE		SP	
	Y	N	Y	N
7. Heart condition, chest pain, high blood pressure, elevated cholesterol, heart murmur, abnormal pulse, stroke, or blood, circulatory or vascular system?	Y	N	Y	N
8. Cancer, tumors, leukemia, moles, melanoma, or basal cell carcinoma?	Y	N	Y	N
9. Diabetes, thyroid, liver, hepatitis, glands or spleen?	Y	N	Y	N
10. Asthma, bronchitis, pneumonia, respiratory problems, or sleep apnea?	Y	N	Y	N
11. Ulcers, stomach, colitis, rectum, intestines, gallbladder, or upper or lower digestive system?	Y	N	Y	N
12. Arthritis or rheumatism?	Y	N	Y	N
13. Kidneys, bladder, or urinary tract?	Y	N	Y	N
14. Genital or reproductive organ problems?	Y	N	Y	N

**\*\*\*For each "YES" answer, identify the question number, Applicant name and provide details requested. Attach additional paper if necessary.\*\*\***

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
<b>Physician's name and complete address:</b>		

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
<b>Physician's name and complete address:</b>		

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
<b>Physician's name and complete address:</b>		

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
<b>Physician's name and complete address:</b>		

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No	If "Yes" list any limitations or residuals:	
<b>Physician's name and complete address:</b>		

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Employee First Name: \_\_\_\_\_ Last Name \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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	EE		SP	
15. Drug or alcohol abuse, or used alcohol or nicotine on a regular basis? Indicate amount used daily: _____	Y	N	Y	N
16. Eyes, ears, nose or throat?	Y	N	Y	N
17. Psychiatric, mental or nervous disorders, including depression and anxiety?	Y	N	Y	N
18. Back, neck, spine, bones or joints?	Y	N	Y	N
19. Immune system, anemia or other blood conditions?	Y	N	Y	N
20. Brain or nervous system problems or epilepsy?	Y	N	Y	N
21. Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), immune deficiency disorder or do you have enlarged lymph nodes or unexplained weight loss?	Y	N	Y	N
22. Are you <b>currently</b> pregnant? If yes, what was your pre-pregnancy weight? _____ lbs.	Y	N	Y	N
23. Are you <b>currently</b> taking medication for any condition or disease?	Y	N	Y	N
24. Any symptoms, injury, birth defect, congenital defect, disease or disorder not mentioned above?	Y	N	Y	N

\*\*\*For each "YES" answer, identify the question number, Applicant name and provide details requested. Attach additional paper if necessary.\*\*\*

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No If "Yes" list any limitations or residuals:		
Physician's name and complete address:		

Question no.	Applicant name:	Medical condition:
Date of diagnosis: / /	Date treatment started: / /	Date treatment ended: / /
Date of last symptom: / /	Current status of condition:	Medications/Treatment:
Any limitations or residuals: Yes / No If "Yes" list any limitations or residuals:		
Physician's name and complete address:		

**Employee Primary Care Physician Name & Address**

**Spouse Primary Care Physician Name & Address**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Notice:** Applicant is required to notify Hartford in writing of any changes in any applicant's medical condition to the best of their knowledge, between the date the Applicant signs this form and the date the coverage is approved.

I hereby certify that the above statement and answers are complete and true to be the best of my knowledge and belief concerning the past and present state of health and medical history of the persons to whom the statement and answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits. 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 is guilty of a crime and may be subject to fines and confinement in prison. This information may be used by Hartford (for fully insured coverages) or my employer/administrator (for self-funded coverages) for plan administration purposes to decide if the person(s) is/are eligible for coverage. I acknowledge that I have read the disclosure notice on the last page of this application.

\_\_\_\_\_  
EMPLOYEE'S SIGNATURE  
or Legal Representative / Relationship to Employee  
(required)

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
SPOUSE'S SIGNATURE  
or Legal Representative / Relationship to Spouse  
(required only if applying for coverage)

\_\_\_\_\_  
DATE SIGNED

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Employee First Name: \_\_\_\_\_ Last Name \_\_\_\_\_ Social Security Number: \_\_\_\_\_

APPLICANT AUTHORIZATION: THIS SECTION IS VERY IMPORTANT. YOUR REQUEST CANNOT BE PROCESSED WITHOUT IT.

**Authorization to Disclose Protected Health Information  
To Be Used To Determine Eligibility for Group Life and/or Disability Income Coverage  
(Group Life and Disability Income are not subject to the requirements of HIPAA)**

**I have applied for insurance under a Group Life and/or Disability Policy issued by Hartford. To assess whether I am eligible for this insurance, these companies may require that I authorize disclosure of a copy of my health information. This authorization is intended to comply with the requirements under §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), effective April 14, 2003.**

I **authorize** any: health plan, physician, medical or health practitioner, counselor, therapist, hospital, clinic, other medical or medically-related facility, or other health care provider who has provided treatment, payment, or services to me or on my behalf within the last 10 years (**Residents of Indiana** authorize within the last 5 years); insurance company; or reinsurance company, with which I have had coverage, and the Medical Information Bureau, Inc. (MIB), (collectively, “Releasers”); to disclose to Hartford, Health Information about me. Hartford may disclose the Health Information: to their agents; to their employees; and to their representatives (collectively “Hartford”); my entire Health Information. Health Information means the entire medical file. This includes, but is not limited to: x-rays; photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes, that relate to: 1) Pre-existing or current illnesses, sicknesses, disease, disabilities, disorders, accidents, injuries, or any other health conditions, 2) Confinements in hospitals, medical facilities, or medical clinics, 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners, 4) Drug use, alcohol use, or mental health information protected by Federal Law, 5)\* Counseling or therapy. Health information also means information on the diagnosis and treatment of mental illness. But, it excludes psychotherapy notes as defined by HIPAA. I understand that the MIB will only disclose health information to Hartford. Hartford will use this information to underwrite my request for coverage; make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to any coverage I have applied for with Hartford.

**\*Residents of West Virginia**, 5) reads as follows: Counseling or therapy, except that no adverse underwriting decision shall be made because I have demonstrated AIDS-related concerns or have sought AIDS-related counseling (this does not apply to my seeking treatment and/or diagnosis for Acquired Immune Deficiency Syndrome).

By signing this Authorization, I acknowledge and agree:

- That any agreements I have made to restrict disclosure of my health information do not apply to this Authorization;
- That I am authorizing the Releasers to release and disclose my entire medical file, as described above, without restriction.

By signing this Authorization, I acknowledge that I understand the following:

- That health information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the Releasers’ knowledge. Note that Hartford only will use this information to underwrite your request for coverage; make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to coverage you have applied for with Hartford.
- That if 1) I refuse to sign this Authorization to release my entire medical file; or 2) if this Authorization is altered by me in any way, Hartford may not be able to process my application for coverage.
- That, if 1) Hartford denies my request for coverage; and 2) this denial is based, in whole or in part, on health information obtained in connection with this Authorization; Hartford will not release this information to me unless otherwise authorized by the Releasers, including my physician or other medical professionals that disclosed such information to Hartford unless required by law.
- That, if necessary, Hartford will send this Authorization to Releasers authorized to release health information about me.
- That Hartford will also provide me with written notice of Releasers to which Hartford sends my Authorization.
- That I have a right, at any time, to revoke this Authorization. To do so, I must send a written request directly to such Releasers. My revocation will not be effective: to the extent that action has been taken in reliance upon this authorization; or, Hartford otherwise has the right: to contest the policy; or a claim under the policy.

**Residents of Virginia**, review this additional text: Authorization signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits remain valid no longer than 30 months from the date the authorization is signed. Authorizations signed for the purpose of collecting information in connection with a claim for accident and sickness benefits under an insurance policy remain valid for the entire term of the coverage of the policy. Authorizations signed for the purpose of collecting information in connection with a claim for any other benefits under an insurance policy remain valid for the duration of the claim.

- That this Authorization will expire 24 months from the effective date of my coverage or if no coverage has been issued, 24 months from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original.
- That I am entitled to a signed copy of this Authorization.

\_\_\_\_\_  
EMPLOYEE’S SIGNATURE  
or Legal Representative/  
Relationship to Employee  
(required)

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
SPOUSE’S SIGNATURE  
or Legal Representative/  
Relationship to Spouse  
(required only if applying for coverage)

\_\_\_\_\_  
DATE SIGNED

## **Variable question language**

### **Florida residents:**

Question 21: Has anyone proposed for coverage ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or had unexplained weight loss or enlarged lymph nodes?

### **Indiana residents:**

Question 24: Please list injury, birth defect, or congenital defect not mentioned above.

### **Maine residents:**

**You are not required to disclose whether you have been tested for HIV, if you have not developed symptoms of the disease AIDS or ARC, in your answer to any of the following questions.**

### **Minnesota residents:**

YOU NEED NOT DISCLOSE AN HIV (AIDS VIRUS) TEST WHICH WAS ADMINISTERED: (1) TO A CRIMINAL OFFENDER OR CRIMINAL VICTIM AS A RESULT OF A CRIME THAT WAS REPORTED TO THE POLICE; (2) TO A PATIENT WHO RECEIVED THE SERVICES OF EMERGENCY MEDICAL SERVICES PERSONNEL AT A HOSPITAL OR MEDICAL CARE FACILITY; (3) TO EMERGENCY MEDICAL PERSONNEL WHO WERE TESTED AS A RESULT OF PERFORMING EMERGENCY MEDICAL SERVICES.

Question 24: Please list any symptom, injury, birth defect, congenital defect, disease, or other disorder not mentioned above that has been diagnosed or treated by a medical practitioner.

### **North Carolina residents:**

Question 21: Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? "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 erythematous, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

### **Vermont residents:**

Question 21: Has anyone been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician?

### **Wisconsin residents:**

Question 6: Had any lab tests, x-ray, electrocardiogram, or other diagnostic testing other than HIV testing or those requested as part of routine physical with normal findings?

## **Disclosure Notice**

I authorize Hartford to release information in its file to the Medical Information Bureau, Inc., and other insurance companies to whom I or my children may apply for Life or Health Insurance, or other persons or organization, performing business or legal services in connection with this application or a claim, or as may be otherwise lawfully required. Except as specified, this information will not be given, sold, or transferred to any person without first obtaining my consent or a written form stating the use and need for such information.

I understand that upon written request, I am entitled to receive details of the procedures I must use to implement my right to access, correct and amend any personal information collected about myself or my children in connection with this application.

I understand that if I request details about any medical record information collected about myself in connection with this application, the medical record information and the identity of the medical care institution, or medical professional that provided the information, shall be supplied only to a licensed medical professional designated by me, unless otherwise authorized by the medical professional or institution who provided such information.

I understand that misstatements, misrepresentations, or omissions in my response to the request for information above may result in the voiding of coverage.

Summary of information: In order to properly underwrite your request for group benefits, Hartford must collect certain information about your physical condition. You are the most important source of information about your own health, and to the degree it is possible, We will rely on only information obtained from you. If We do find We are required to contact a medical professional or institution, We may contact them directly using the authorization on the application form.

Information We collect about you will not be given to anyone without your consent, except when it is necessary for conducting our business. The only people that have access to the information are employees who service your benefits or claims and those who have a regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

In most cases the only information We will collect is provided by you. You are encouraged to keep a copy of this form for your records. If We find it necessary to contact medical providers or institutions, there are procedures by which you can obtain access to the personal information about you which We have collected. Upon written request, We will provide you with information in your file. Medical information will be disclosed only through a physician you designate, unless otherwise authorized by the medical professional or institution who provided such information to Us. Details regarding your right to correct or amend information in your file will be furnished upon written request. If you have any further questions about these policies and practices, please write to: Group Medical Underwriting, Hartford Life Insurance Companies, PO Box 1590, Avon, CT 06001-1590.

Answer questions for each Applicant. Provide details for all questions 1-24 answered "Yes".