

Request for Term Insurance Application



Questions? Call Individual Life Sales and Marketing at 1-800-800-2738 (option 1, then option 2).

Proposed Insured Information				
Proposed Insured Name		Social Security Number		Date of Birth / /
		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Street Address		City		State
ZIP Code				
Home Phone ()	Business Phone ()	Preferred Phone Number to Call for Phone Interview <input type="checkbox"/> Home <input type="checkbox"/> Business		Preferred Time to Call <input type="checkbox"/> 8am-12pm <input type="checkbox"/> 5pm-9pm <input type="checkbox"/> 12pm-5pm <input type="checkbox"/> Anytime
Companion or Related Application Information				
Is There a Companion or Related Application? <input type="checkbox"/> No <input type="checkbox"/> Yes. If selected, provide details at right:		Name of Companion Insured		Insurance Type <input type="checkbox"/> Permanent <input type="checkbox"/> Term
Policyowner Information Complete this section only if the proposed insured is not the policyowner.				
Policyowner Name		Social Security Number		Date of Birth / /
Relationship to Proposed Insured		The Policyowner Is a/an <input type="checkbox"/> Individual <input type="checkbox"/> Trust <input type="checkbox"/> Other. Please specify: _____		
Street Address		City		State
ZIP Code				
Payor Information Complete this section only if the policyowner is not the payor.				
Payor Name		Street Address		City
				State
ZIP Code				
Policy Information				
Product (Select only one) <input type="checkbox"/> Hartford Term 10 <input type="checkbox"/> Hartford Term 15 <input type="checkbox"/> Hartford Term 20 <input type="checkbox"/> Hartford Term 30		Death Benefit/ Coverage Amount \$		U.S. State in which Application Will Be Signed <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px auto;"></div>
Riders <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Child Rider: <input type="radio"/> \$5,000 <input type="radio"/> \$10,000 Available only for children under 14 years of age. If selected, provide details below:				
		Child's Name		Date of Birth / /
				/ /
				/ /
Premium Quoted <input type="checkbox"/> Non-Nicotine <input type="checkbox"/> Nicotine		Modal Premium Quoted \$		Payment Mode <input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly EFT
Beneficiary Information All multiple beneficiary designations will be equally divided among beneficiaries unless otherwise indicated.				
Primary Beneficiary		Relationship to Proposed Insured		Date of Birth / /
Contingent Beneficiary		Relationship to Proposed Insured		Date of Birth / /
Existing Life Insurance and Annuity Coverage Information				
Does the proposed insured have existing life insurance or annuity coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes. If selected, provide details below:				
Details for Existing Coverage <i>Note: The Hartford does not allow 1035 exchanges on term policies.</i>				
Company Name		Amount		Policy Number
				Type
				<input type="checkbox"/> Individual <input type="checkbox"/> Yes <input type="checkbox"/> Business <input type="checkbox"/> No <input type="checkbox"/> Group
				<input type="checkbox"/> Individual <input type="checkbox"/> Yes <input type="checkbox"/> Business <input type="checkbox"/> No <input type="checkbox"/> Group
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Producer Information Must be completed.				
Producer Name		Producer Social Security Number		Firm Name
Producer Phone Number ()		Producer Fax Number ()		Producer ZIP Code
Producer Email Address			Hartford Producer Code	
Remarks:				
Mail or fax this request along with all applicable forms to:		Address: The Hartford Individual Life Operations P.O. Box 64271, St. Paul MN 55164		Fax: 651-738-4187

Authorization to Obtain, Release, and Disclose Information

I, an undersigned Proposed Insured, authorize Hartford Life and Annuity Insurance Company ("The Hartford") to complete a Personal History Interview and to obtain an Investigative Consumer Report on me (and on my minor children if they are applying for insurance). Further, I authorize the release of any medical or non-medical information that relates to me (and my minor children if they are applying for insurance) that is necessary for my application or determining eligibility for benefits, including (1) past or current health conditions including illnesses, sicknesses, diseases, disabilities, disorders, accidents, injuries, and drug prescriptions; (2) confinements in any hospital, medical facility, VA facility or medical clinic; (3) outpatient treatment in any hospital, hospital emergency room, medical facility, VA facility or medical clinic; and (4) treatment for alcohol abuse, drug abuse or mental health protected by Federal Law.

I authorize any person or organization that has records or knowledge of my health or driving record (and the health or driving record of my minor children, if they are applying for insurance) to release this information. This includes any doctor, medical professional, health practitioner, therapist, counselor, hospital, clinic or any other medically related facility, pharmacy benefit manager, VA facility or medical clinic, other insurance company, reinsurer, consumer reporting firm, employer, Motor Vehicle Division or the Medical Information Bureau (MIB). This information may be released for the purpose of determining eligibility for insurance under a new or an existing policy and/or eligibility for any benefits under the policy in the event of a claim. This information may be released to The Hartford or its legal representative. However, I understand that the MIB will release records of information only to The Hartford.

I understand that The Hartford may release this information in its file(s) to its reinsurer(s), the MIB, any other insurance company to which I or my minor children apply for life or health insurance, other persons and/or organizations performing business or legal services in connection with this application or a claim, or as required by law, including any mandated reporting to state agencies. I understand that if I request details about any of the medical information gathered about me or my minor children which relates to this application: (a) the medical information and (b) the identity of the medical care institution or the medical person who provided the information shall be released to me or to a licensed medical person of my choice. I also acknowledge receipt of The Hartford's Notice of Information Practices.

I agree that a photocopy of this authorization is as valid as the original and understand that I may receive a copy of this authorization upon request. I also agree that this authorization shall be valid for twenty-four (24) months from the date shown below. This authorization may be revoked upon written request, except to the extent that action has already been taken. I understand that revocation may be a basis for denying insurance coverage and benefits.

HL-15856REV(05)CW

**Signature of Proposed Insured/Patient or Personal Representative
(Parent or guardian if under 15 years of age)**

_____/_____/_____
Date

Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 20 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Hartford Life and Annuity Insurance Company (Hartford) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Hartford may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Hartford.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Hartford Life at P.O. Box 64271, St. Paul, MN 55164, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization or to the extent that Hartford has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Hartford may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Print Name of Proposed Insured/Patient

_____/_____/_____
Date of Birth

Social Security Number

Signature of Proposed Insured/Patient or Personal Representative

_____/_____/_____
Date

Description of Personal Representative's Authority or Relationship to Patient (For example, parent or guardian.)

Producer: You must remove this notice and leave it with the Proposed Insured(s).

Hartford Life and Annuity Insurance Company
Individual Life Operations Address:
P.O. Box 64271
St. Paul, Minnesota 55164-0271

Notice of Insurance Information Practices

Investigative Consumer Reports

As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. You have the right to send a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

Personal History Interview

To provide you, our client, with the best possible service, we may also conduct what we call a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the application information is complete. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

Medical Information Bureau (MIB) Pre-Notification

Information regarding your insurability will be treated as confidential. Hartford Life and Annuity Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life 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, the MIB, upon request, will supply such a company, with the information in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact the MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Access, Correction and Disclosure

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant.

Hartford Life and Annuity Insurance Company or its reinsurer(s) may release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Also, please be advised that personal and confidential information collected by us may, in certain circumstances, be disclosed to third parties without authorization. A further description of the circumstances under which information about you may be disclosed and the types of persons and organizations to whom it may be disclosed will be sent to you upon your written request.

If you desire further information or access to your personal information, please send your written request to: Hartford Life and Annuity Insurance Company, P.O. Box 64271, St. Paul, MN 55164.

What Happens Next?

Important Information for Clients of Hartford Life Insurance

Now that you have decided to apply for term life insurance from The Hartford, we want you to know what happens next. The following information is designed to help you prepare for the application process.

- Your insurance agent will ask you to provide two signatures: one for the Authorization to Obtain Release and Disclose information (MIB) and one for the Authorization for Release of Health Related Information (HIPAA). These documents allow The Hartford to obtain your medical information that will be used to make an underwriting decision. If you are replacing an existing policy, you may also be required to sign state replacement forms, which will be provided by your insurance agent.
- To assess your insurability, The Hartford undertakes a thorough health evaluation that covers your nicotine use, blood pressure, cholesterol levels, body build, family history, medical history and motor vehicle record.
- A representative from one of The Hartford's tele-interviewing companies will call you to complete the application during your preferred time frame. Please plan on approximately 20–30 minutes to complete your interview.

To limit the time needed to gather the necessary information to complete your interview, please use the following list and have the following information available at the time of your appointment.

1. Your driver's license number and state, annual income, and estimated net worth.
2. For all existing life insurance policies, the name of the provider and the amount of coverage.
3. All prescription medications you currently take, the dosage, and the frequency.
4. For all doctors currently seen or specialists seen within the past five years, the name, address with city/state/ZIP, telephone number, and date and reason for the last visit.
5. A representative from the examining company will contact you to set an appointment for a medical exam.
6. A paramedical professional will visit you for an examination that includes measuring your height, weight, blood pressure, and heart rate. In addition, the paramedical professional will collect blood and urine samples. Your exam may include additional tests, such as an EKG or treadmill EKG, depending on your age and medical history or the benefit amount.

Note: You may receive your own copy of the examination results as state law allows at no cost from The Hartford:

By writing: The Hartford Individual Life Operations, P.O. Box 64582
St. Paul, MN 55164, Attention: Underwriting Department

By faxing: 1-651-738-4187. Your fax request must contain your signature.

- Once you have completed the health evaluation and medical exam, the underwriter will review your medical information to assess your eligibility and health class, which determines the cost of your coverage.
- If the underwriter approves your application, your insurance agent will call you to review and sign the completed application and deliver a policy.
- If your health history has not changed since your request for application, your coverage begins once you have signed the application and all required paperwork, your policy has been delivered, and the appropriate premium has been submitted.
- The Hartford is The Hartford Financial Services Group, Inc. and its subsidiaries, including the issuing companies of Hartford Life Insurance Company and Hartford Life and Annuity Insurance Company.



INSURANCE MARKETPLACE
STANDARDS ASSOCIATION

*Committed to honesty,
integrity and ethics*

Life insurance products:

- ✓ **are not** insured by the FDIC;
- ✓ **are not** insured by any federal agency; and
- ✓ **are not** guaranteed by, or obligations or deposits of, any bank or any affiliate, or credit union.



Issuers: Hartford Life Insurance Company (New York)
Hartford Life and Annuity Insurance Company (Outside New York)
200 Hopmeadow Street, Simsbury, CT 06070

Mailing address: P.O. Box 2999, Hartford, CT 06104-2999
for both issuers: www.hartfordinvestor.com

