ASSOCIATION OF THE UNITED STATES ARMY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
ONE HARTFORD PLAZA
HARTFORD, CONNECTICUT 06155
(A STOCK INSURANCE COMPANY)

MAIL YOUR COMPLETED APPLICATION TO:
AUSA GROUP INSURANCE PROGRAM
1200 E. GLEN AVE. PEORIA HEIGHTS, IL 61616-5348

QUESTIONS?
CALL 1.800.882.5707 OR
EMAIL CUSTOMERSERVICE@AUSACOVERAGE.COM

AUSA GROUP TERM LIFE INSURANCE PLAN APPLICATION

1. COMPLETE AND SIGN THE APPLICATION.
2. SEND NO MONEY WITH YOUR APPLICATION. YOU WILL BE BILLED UPON APPROVAL.
3. PLEASE RETURN TO:
AUSA GROUP INSURANCE PROGRAM
1200 E. GLEN AVE. PEORIA HEIGHTS, IL 61616-5348

1. PLEASE COMPLETE THE FOLLOWING INFORMATION:

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zipcode _____

Height _____ Weight _____ Date of Birth (MM/DD/YY) _____ Place Of Birth (State/Country) _____

Member Social Security Number _____ Daytime Phone Number _____

Sex: ❍ Male ❍ Female Email Address _____

Beneficiary – Print Full Name _____ Relationship To You _____

2. PLEASE COMPLETE FAMILY INFORMATION (IF APPLYING)

Spouse Name (Last, First, Middle Initial) _____

Sex: ❍ Male ❍ Female Date of Birth (MM/DD/YY) _____ Height _____ Weight _____

Place of Birth (State/County) _____

Child Name: _____ Date of Birth (MM/DD/YY) _____ **Sex: ❍ M ❍ F**

Child Name: _____ Date of Birth (MM/DD/YY) _____ **Sex: ❍ M ❍ F**

Child Name: _____ Date of Birth (MM/DD/YY) _____ **Sex: ❍ M ❍ F**

3. SELECT THE AMOUNT OF COVERAGE DESIRED ($160,000 MINIMUM UP TO $500,000 MAXIMUM IN $10,000 INCREMENTS)

Please indicate if request is for new coverage: ❍ New Coverage Member Amount Desired $ _____ Spouse Amount Desired $ _____

4. PLEASE COMPLETE THE FOLLOWING QUESTIONS:

	MEMBER	SPOUSE
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 no 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?	❍ Y ❍ N	❍ Y ❍ N
2. In the past 10 years has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for:		
A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?	❍ Y ❍ N	❍ Y ❍ N
B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system or sleep disorder?	❍ Y ❍ N	❍ Y ❍ N
C. Colitis, ulcer, kidney disease or any disease or disorder of the digestive, urinary or reproductive systems?	❍ Y ❍ N	❍ Y ❍ N
D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	❍ Y ❍ N	❍ Y ❍ N
E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands or thyroid?	❍ Y ❍ N	❍ Y ❍ N
F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?	❍ Y ❍ N	❍ Y ❍ N
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	❍ Y ❍ N	❍ Y ❍ N
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?	❍ Y ❍ N	❍ Y ❍ N

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

QUESTION NUMBER AND CONDITION	NAME OF FAMILY MEMBER	FOR ANY QUESTION ANSWERED "YES" PLEASE PROVIDE YOUR PHYSICIAN'S NAME, FULL ADDRESS AND PHONE NUMBER (REQUIRED FOR PROCESSING)

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

5. PLEASE READ CAREFULLY ALL ITEMS AND SIGN:

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 Hartford, 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 understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. 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 The Hartford 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 except drug and alcohol treatment information.

The Hartford 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.

I authorize The Hartford to give information about me to any other insurance company to whom I or my dependent 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 or authorized 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. I agree that this document and all of its contents shall form a part of my enrollment request for group benefits.

Notice: I understand that California law prohibits an HIV test from being required or used by Health Insurance Companies as a condition of obtaining health insurance coverage

Member's Signature X | **Date** (MM/DD/YY)

Spouse's Signature (If enrolling) **X** | **Date** (MM/DD/YY)

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?

Member: ❍ Y ❍ N **Spouse:** ❍ Y ❍ N

6. 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.

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QUESTIONS? CALL NOW: 1.800.882.5707

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1200 E. GLEN AVE.
PEORIA HEIGHTS, IL 61616-5384

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Notice of Information Practices

This notice applies to residents of: All states, excluding Massachusetts.

The Hartford Life and Accident Company respects your right to privacy and values your trust. This Notice explains how we collect, use and protect your personal information and your rights regarding that information.

Information We Collect: While your application for insurance is our primary source of information about you, we may also need to collect or verify information from other sources such as physicians and other medical and health care providers and professionals, health facilities such as hospitals, clinics, pharmacies, employers, consumer reporting agencies, and insurance-support organizations, which may provide us with an investigative consumer report about you. Organizations that provide us with consumer reports about you may disclose the contents of the report to others for which such organization performs such services. We may collect personal information about you that is necessary to determine your eligibility for insurance, to service your insurance policy, and otherwise as permitted by law; the information may include information from which judgments can be made about your age, health and medical history, occupation, avocations, finances, credit, character, habits, general reputation, or any other personal characteristics. We also collect information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment and claims history.

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-Notice: Information regarding your insurability will be treated as confidential. Hartford Life and Accident Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-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 about you in its file. Upon receipt of a request 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 the 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 Model 400, Braintree, Massachusetts 02184-8734. Hartford Life and Accident Insurance Company, or their reinsurers, may also release information from their files 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.

Disclosure of Personal Information: We will not disclose your personal information to third parties without your authorization except in connection with our business or as otherwise permitted or required by law. For example, in connection with our general business practices, we may disclose personal information we collect to: companies performing services or functions on our behalf, including other insurers, agents or insurance support organizations, including for the purpose of determining your eligibility for insurance benefits or payments; detect or prevent fraud or criminal activity in connection with insurance transactions; medical care institutions or medical professionals for the purposes of verifying coverage or benefits; insurance regulatory authorities or law enforcement of other governmental authorities to prevent or prosecute the perpetration of fraud; the policyholder of a group insurance policy (for example an employer who provides group insurance) for purposes of reporting claims experience, conducting an audit of our operations or services, risk mitigation or other permissible purposes; third parties who collect data regarding claims for purposes of underwriting and claims handling, or to a third party as otherwise permitted or required by law; or reinsurers.

Form PA-10210 (2018)

How We Protect Your Information: We employ administrative, technical and physical safeguards to protect the security, confidentiality and integrity of personal information. We will continue to protect your information even when a business relationship no longer exists between us.

Right to Access and Right to Correct/Amend/Delete: You have the right to learn what personal, including medical, information we have in our files about you, to whom it has been recently disclosed, to have access to the information, to correct the information, and to receive a copy. We are not required to provide you access to information that is collected when we evaluate a claim or when the possibility of a lawsuit exists.

Please contact us if you would like access to your information from your files. There may be a reasonable charge for copies of records. If you think your file contains incorrect information, notify us indicating what you believe is incorrect and your reasons. We will investigate the matter and either correct our records or place a statement from you in our files explaining why you believe the information is incorrect. We will also notify persons or organizations to whom we previously disclosed the information of the change or your statement.

If you request access to medical record information that was supplied to us by a medical care institution or medical professional, we may choose to provide it to a medical professional designated by you.

Rights Relating to Adverse Underwriting Decision: You have the right to certain information relating to adverse underwriting decisions we may make about You, including the reason for such decision. In the event we make an adverse underwriting decision relating to You, we will provide You with information regarding such decision and Your rights.

How to make a request: If you wish to exercise your rights as provided in this notice, please provide us with your full name, complete address, your policy number or other identifying information and a reasonable description of the information you wish to access or correct. Please send your written request to: The Hartford, Attn: Medical Underwriting, PO Box 2999, Hartford, CT 06104-2999.