



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: <input type="radio"/> Male <input type="radio"/> Female		Email Address	
Beneficiary – Print Full Name		Relationship To You	

2. PLEASE COMPLETE FAMILY INFORMATION (IF APPLYING)

Spouse Name (Last, First, Middle Initial)			
Sex: <input type="radio"/> Male <input type="radio"/> Female	Date of Birth (MM/DD/YY)	Height	Weight
Place of Birth (State/County)			
Child Name:	Date of Birth (MM/DD/YY)	Sex: <input type="radio"/> M <input type="radio"/> F	
Child Name:	Date of Birth (MM/DD/YY)	Sex: <input type="radio"/> M <input type="radio"/> F	
Child Name:	Date of Birth (MM/DD/YY)	Sex: <input type="radio"/> M <input type="radio"/> 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 \$
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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

All questions are answered to the best of my knowledge and belief:

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?

Y N

Y N

C. Colitis, ulcer, kidney disease or disorder, or liver disease or disorder, 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?

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?

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/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.

Subject to the deferred effective date provision, 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/our 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 or my/our dependent's 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 or my/our dependents 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 or my/our dependents 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.

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.

SEND NO MONEY WITH YOUR APPLICATION. YOU WILL BE BILLED UPON APPROVAL.

QUESTIONS? CALL NOW: 1.800.882.5707

PLEASE COMPLETE FORM AND RETURN TO:

AUSA GROUP INSURANCE PROGRAM

1200 E. GLEN AVE.

PEORIA HEIGHTS, IL 61616-5384

Signature of Applicant: X

Date (MM/DD/YY)

Signature of Applicant: X

Date (MM/DD/YY)

Do you intend to replace, in whole or in part, any existing life insurance or annuity? Y N

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing company, Hartford Life and Accident Insurance Company.

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.

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

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.

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Form PA-10210 (2018)



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: _____