HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

Administered by: Pearl Insurance
Group Term Life Insurance Enrollment Form
Members age 54 and younger
Group Policyholder: Association of the United States Army
(AUSA) Policy # AGL-1978

SECTION 1				
Member Information				
Member Name:		**AUSA Membership Number:**		
☐ **Are you a Member of the AUSA?**				
Street:	**City:**		**State:**	**Zip:**
Member's Social Security Number:	**Member's Date of Birth:**		**Gender:** ☐ **Male** ☐ **Female**	
Email Address:		**Daytime Phone Number:**	**Member Occupation:***	

*__Important Note:__ You must meet all requirements for professional membership in AUSA to enroll for this life insurance coverage.

SECTION 2
Coverage Information
Life Insurance
Member: ☐ $100,000 (This Guaranteed Issue Offer is only available 90 days after discharge if you are under age 55)
By enrolling for this insurance, do you intend to replace, discontinue or change an existing policy of Life Insurance? If not, simply check "No". Member: ☐ Yes ☐ No
To enroll: Mail your completed enrollment form to: 1200 E. Glen Ave, Peoria Heights, IL 61616-5348 Please mail within 10 days Questions? Call 1 (800) 882-5707 or email customerservice@ausacoverage.com

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Life Form Series includes GBD-1000, GBD-1100, or state equivalent

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SECTION 3
Confirmation

I acknowledge that I have been given the opportunity to enroll in the AUSA Group Term Life Insurance Plan. I also acknowledge that I am age 54 and younger, an Association Member who meets all requirements for professional membership in the Association and that the above information is true and complete to the best of my knowledge and belief. If I enroll today and want to upgrade coverage at a later date, I may be required to submit Evidence of Insurability.

I understand and agree that insurance will go into effect upon receipt of my first premium payment and this form and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy and certificate. I understand and agree that only the insurance policy and certificate issued to Association can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form insurance policy and certificate, I agree to be bound by the terms and conditions of the certificate.

I understand that the policy permits the policyholder to change, reduce, restrict or terminate my rights or benefits under the policy without my consent. Such change, reduction, restriction or termination may occur at a time when a covered person's health status has changed and may affect their ability to procure individual coverage.

Do you wish to receive your Certificate of Insurance by secure email?	☐ Yes ☐ No
If the "Yes" checkbox is selected, please provide your email address:	

Read your certificate carefully.
Certain war risks are not covered.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

I have read the Important Replacement Notice included with the application.

Member Signature:		Date:

SECTION 4			
Payment Options			
Credit Card (Automatic Withdrawal):			
Payment/Billing Frequency:			
Payment Type:			
Card Number:		Expiration Date:	
Automatic Bank Withdrawal (Electronic Funds Transfer):			
Name:	Banking Institution:	Routing Number:	
Account Number:	Bank Account Type:	☐ Checking	☐ Savings

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For your convenience you will be billed quarterly.

I authorize the Administrator to initiate credit card payments or debit entries for my regular payment from the credit card or bank account provided above. I understand that payment will be processed on or after the due date and will continue to be charged or deducted from my account unless I notify the Administrator otherwise in writing or my coverage ends. I also understand if corrections of the debit are necessary, this may involve an adjustment to my account.

Member Signature:		Date:

SECTION 5

Fraud Notice(s)

For Residents of Florida:
Any person who 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 is guilty of a felony of the third degree.

For Residents of Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For Residents of Louisiana:
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.

For Residents of Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New Jersey
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For Residents of Virginia
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement may have violated the state law.

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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: ___________________________________

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