

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



**Group Term Life Insurance Enrollment Form**  
**Group Policyholder: Association of the United States Army (AUSA)**  
**Policy # AGL-1978**

**SECTION 1**

**MEMBER INFORMATION**

**Member's Name:** \_\_\_\_\_ **Association Membership Number:** \_\_\_\_\_

Are you a Member of the Association?  Yes  No

**Street:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Member's Social Security Number:** \_\_\_\_\_ **Member's Date of Birth:** \_\_\_\_\_ **Gender:**  Male  Female

**Email Address:** \_\_\_\_\_ **Daytime Phone Number:** \_\_\_\_\_

**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

**SECTION 3**

**CONFIRMATION**

I acknowledge that I have been given the opportunity to enroll in the **AUSA Group Term Life Insurance Plan**. I certify that I am under age 55, an Association Member and that the above information is true and complete to the best of my knowledge. 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. I understand and agree that only the insurance policy 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 and the insurance policy, I agree to be bound by the insurance policy

I understand that during the first two years of coverage, the benefit payable for death due to sickness will be the premiums paid plus annual interest. After two years of coverage, the benefit payable for death due to sickness will be the full benefit amount. At any time, the benefit payable for death due to accident will be the full amount. If I have Life Insurance with The Hartford, I understand and agree that my Life Insurance benefit(s) reduce at a specified age(s) stated in the policy.

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: \_\_\_\_\_

**Member's Signature** (sign name in full): \_\_\_\_\_ **Date:** \_\_\_\_\_

## SECTION 4

**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 New York (Not applicable to Life Insurance):** 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 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**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.

### TO ENROLL:

**MAIL YOUR COMPLETED ENROLLMENT FORM TO:**

**1200 E. GLEN AVE, PEORIA HEIGHTS, IL 61616-5348**

**QUESTIONS? CALL 1 (800) 882-5707**

**EMAIL CUSTOMERSERVICE@AUSACOVERAGE.COM**

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