



APPLICATION FOR THE SENIOR DISABILITY INCOME INSURANCE PLAN

Hartford Life And Accident Insurance Company

Hartford, Connecticut 01655



amta american massage therapy association

Official Member No.: \_\_\_\_\_
Name: \_\_\_\_\_
Address: \_\_\_\_\_
City/State/Zip: \_\_\_\_\_

1

Policyholder: AMERICAN MASSAGE THERAPY ASSOCIATION
Policy No.: AGP-5667
Certificate No.: (Leave Blank)

2

Please Complete

MEMBER NAME (First, Middle Initial, Last)
Street
City, State, Zip Code
Phone Number ( ) -
Email
Date of Birth M M D D Y Y Y Y Gender: Male Female Height: ft. in. Weight: lbs.
Age Last Birthday Place of Birth (City/State/Country)
Occupation
Business Address
City, State, Zip Code
Business Phone Number ( ) - Annual Salary
Beneficiary - Print full name & relationship to you
Name: Relationship:

3

Please Complete

SPOUSE/DOMESTIC PARTNER NAME (First, Middle Initial, Last)
Street
City, State, Zip Code
Phone Number ( ) -
Email
Date of Birth M M D D Y Y Y Y Gender: Male Female Height: ft. in. Weight: lbs.
Age Last Birthday Place of Birth (City/State/Country)
Occupation
Business Address
City, State, Zip Code
Business Phone Number ( ) - Annual Salary

Beneficiary - Print full name & relationship to you

Name:

Relationship:

The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

#### 4 Please Select Your Desired Coverage

##### MEMBER

Senior Plan (\$400 – \$6,000)

Monthly Benefit Amount\*

Check Your Waiting Period:

30 days  60 days  90 days  180 days

\*Benefits are available in \$100 increments with a minimum benefit of \$400.

##### SPOUSE/DOMESTIC PARTNER

Senior Plan (\$400 – \$6,000)

Monthly Benefit Amount\*

Check Your Waiting Period:

30 days  60 days  90 days  180 days

#### 5 Please Complete the Following

		<b>Spouse/Domestic</b>	
		<b>You</b>	<b>Partner</b>
Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 30 hours per week) 90 days before the date of this application? .....	YES	NO	YES NO
Do you have any Disability Income Insurance in force or pending in this or any other company? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>

Name	Company	Monthly Benefit	Benefit Period	Waiting Period	To be replaced?
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No

		<b>Spouse/Domestic</b>	
		<b>You</b>	<b>Partner</b>
Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Basic Monthly Pay minus any Other Income Benefits? .....	YES	NO	YES NO
<input type="radio"/> I am a current AMTA Member. <input type="radio"/> I have been a member of AMTA for less than 60 days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>

#### 6 Please Complete the Following

		<b>Spouse/Domestic</b>	
		<b>You</b>	<b>Partner</b>
At any time during the past 12 months to the present, has anyone proposed for coverage smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff? .....	YES	NO	YES NO
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>

#### 7 Please Complete the Following

ALL QUESTIONS ARE ANSWERED TO THE BEST OF MY KNOWLEDGE AND BELIEF:

		<b>Spouse/Domestic</b>	
		<b>Member</b>	<b>Partner</b>
1. In the past 10 years, has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for:	YES	NO	YES NO
A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>
B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>
C. Colitis, ulcer, kidney disease or disorder or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system? ..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>
D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>
E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>
F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders? ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder excluding HIV tests?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>
2. 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 been confined or treated in any hospital, sanatorium or similar institution? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>
3. Is anyone proposed for coverage now pregnant? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>
If yes, Name: _____ When is the baby due? _____			
What was your pre-pregnancy weight?: _____			
Are there any medical complications? .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> <input type="radio"/>

**8**

**Please Complete the Following**

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)	Date

Attach sheet of paper if additional space is needed. Sign and date additional sheet of paper.

**9**

**Please Read Carefully All Items and Sign Below**

**AUTHORIZATION:** I hereby certify that I have read or have had read to me 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 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 pay the 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 Hartford Life and Accident Insurance Company or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage.

Hartford Life and Accident Insurance Company will use the information to decide if and to what extent I am 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 Hartford Life and Accident Insurance Company.

I authorize Hartford Life and Accident Insurance Company to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I may apply for Life or 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 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, 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.

**PRE-EXISTING CONDITIONS LIMITATION:** I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until one (1) year after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation.

I further understand that any condition excluded or limited by the policy or by a Health Waiver attached to my certificate will not be covered under this policy at any time.

**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.

**SIGN & DATE** 

**Signature of Applicant**

**Date**   -   -      
**MM DD YYYY**

**SIGN & DATE** 

**Signature of Spouse**

**Date**   -   -      
**MM DD YYYY**

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 may be guilty of a crime and may be subject to fines and confinement in prison.



**amta**  
 american **massage therapy** association®

**Return completed form today to:**  
 AMTA Optional Insurance Program,  
 P.O. Box 26860,  
 Phoenix, AZ 85068

**Questions?**  
 Call toll-free 1-866-803-6830  
**SEND NO MONEY NOW!**

Disability Forms Series includes GBD-1000,  
 GBD-1200, or state equivalent.