APPLICATION FOR THE SENIOR DISABILITY INCOME INSURANCE PLAN

Hartford Life And Accident Insurance Company

Hartford, Connecticut 01655

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: ______

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

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 ______

Continued →

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

SPOUSE/DOMESTIC PARTNER

◯ 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.

5 Please Complete the Following

	You YES	You NO	Spouse/Domestic Partner YES	Spouse/Domestic Partner NO
Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 30 hours per week) immediately before the date of this application?	◯	◯	◯	◯
Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company? If yes, give details.	◯	◯	◯	◯

Name	Company	Monthly Benefit	Benefit Period	Waiting Period	To be replaced?
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

	You YES	You NO	Spouse/Domestic Partner YES	Spouse/Domestic Partner NO
Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Basic Monthly Pay minus any Other Income Benefits?	◯	◯	◯	◯

◯ I am a current AMTA Member. ◯ I have been a member of AMTA for less than 60 days.

6 Please Complete the Following

	You YES	You NO	Spouse/Domestic Partner YES	Spouse/Domestic Partner NO
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?	◯	◯	◯	◯

7 Please Complete the Following

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

	Member YES	Member NO	Spouse/Domestic Partner YES	Spouse/Domestic Partner NO
1. In the past 10 years, has anyone proposed for coverage 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?	◯	◯	◯	◯
B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?	◯	◯	◯	◯
C. Colitis, ulcer, liver, kidney disease or disorder or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system?	◯	◯	◯	◯
D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	◯	◯	◯	◯
E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?	◯	◯	◯	◯
F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?	◯	◯	◯	◯
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder excluding HIV tests?	◯	◯	◯	◯
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?	◯	◯	◯	◯
3. Is anyone proposed for coverage now pregnant?	◯	◯	◯	◯

If yes, Name: ______ When is the baby due? ______

What was your pre-pregnancy weight?: ______

	Member YES	Member NO	Spouse/Domestic Partner YES	Spouse/Domestic Partner NO
Are there any medical complications?	◯	◯	◯	◯

Continued →

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.

8 Please Read Carefully All Items and Sign Below

AUTHORIZATION: I/We hereby certify that I/we have read or have had read to me/us 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 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/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 pay the 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 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 information to decide if and to what extent we 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: its reinsurer(s), any other insurance company to whom I/we 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/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.

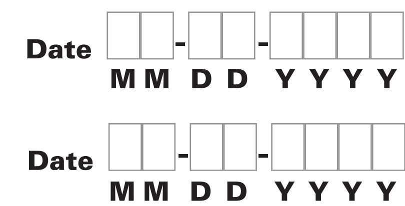
I/We understand that upon written request I/we may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my/our coverage or, if no coverage has been issued one (1) year from 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 its contents shall form a part of my/our enrollment request for group benefits.

PRE-EXISTING CONDITIONS LIMITATION: I/We understand that any injury or sickness, diagnosed or undiagnosed, for which I/we have received medical advice or treatment in the 12 month period prior to my/our effective date of coverage will not be covered until I/we have gone 12 months ending on or after my/our effective date of coverage without medical advice or treatment for that condition, or until 1 year after my/our 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/our certificate. Applications to increase coverage will be subject to a new pre_existing conditions limitation.

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



FRAUD WARNING STATEMENT: 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.

PA-9357 (HL) (NY) (2-12) 44557

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.

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100944 (Member) 100945 (Spouse)

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