SEND NO MONEY NOW!

amta
american massage therapy association

American Massage Therapy Association

Disability Income Insurance Application

THE HARTFORD

Hartford Life and Accident Insurance Company
Hartford, Connecticut 06155

Policy #AGP-5874

1. POLICYHOLDER: American Massage Therapy Association

Member Number:

2.

Member Name: (First, Middle, Last)

Street: City State Zip Code

Phone No.: ( ) - E-mail Address:

Date of Birth: Month / Day / Year Place of Birth: State, Country

Male: ◯ Female: ◯ Height: ft. in. Weight: lb.

Beneficiary — Print full name & relationship to you

Name: Relationship:

The Member will be the beneficiary for any Dependent Coverage desired.

3.

Spouse's Name: (First, Middle, Last)

Street: City State Zip Code

Phone No.: ( ) - E-mail Address:

Date of Birth: Month / Day / Year Place of Birth: State, Country

Male: ◯ Female: ◯ Height: ft. in. Weight: lb.

4. COVERAGE REQUESTED:

Member Coverage:

◯ $400 ◯ $1,000 ◯ $1,500 ◯ $2,000 ◯ $2,500 ◯ $3,000 ◯ $3,500 ◯ $4,000

Spouse Coverage:

◯ $400 ◯ $1,000 ◯ $1,500 ◯ $2,000 ◯ $2,500 ◯ $3,000 ◯ $3,500 ◯ $4,000

Check Elimination Period for you and your spouse (if applying):

◯ 45 days ◯ 60 days ◯ 90 days ◯ 180 days

5.

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
Is the Monthly Benefit Amount herein applied for equal to or less than 70% of your Pre-disability Earnings?	○	○	○	○

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

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
1. During the last 5 years, have you or your Spouse been diagnosed or been treated for cancer, tumor, high blood pressure, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any disease or disorder of the glands, any lung or respiratory disorder, liver, kidney or genitourinary disorder, alcohol or drug dependency, mental or nervous disorder, bone, joint, back, muscle or connective tissue disorder, or chronic fatigue syndrome?	○	○	○	○
2. Have you or your Spouse ever been diagnosed or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	○	○	○	○
3. Have you or your Spouse been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity)?	○	○	○	○

7. Please review your answer to these questions to be sure that you have answered them fully and truthfully. A misrepresentation on the questions could void your coverage.

We understand that coverage will not become effective until the Company grants its underwriting approval and the administrator is in receipt of the first payment of premium. We do not receive temporary or conditional insurance coverage just because we submit an application.

By signing below, we acknowledge that we have read and agree to all terms on the reverse of this form.

8. **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

CONTINUED ➡

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 two (2) years 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.

Member's signature (Sign name in full)

Required

Date

Required

Spouse's signature (if applying)

Required

Date

Required

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.

AGIA
AFFINITY

AMTA Optional Insurance Program
P.O. Box 26860
Phoenix, AZ 85068
1-866-803-6773
Administered by
A.G.I.A., Inc.

If you answered “Yes” to any of the above questions, provide the details below to include the condition, diagnosis, number of episodes, duration, severity, date of last symptom, current status, treatment, medications and dosages, test results, any further treatments planned and the medical professionals and hospital’s name, address and phone number. If additional space is needed, provide additional sheet with details.

Question Number, Condition, Dates and Details	Name of Family Member	Medical professional’s name, full address and phone number

AMTA Optional Insurance Program
P.O. Box 26860
Phoenix, AZ 85068
1-866-803-6773
Administered by
A.G.I.A., Inc.