THE HARTFORD

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:	Policy No.:	Certificate No.: (Leave Blank)
AMERICAN MASSAGE THERAPY ASSOCIATION	**AGP-5874**	

2 Please Complete

MEMBER NAME (First, Middle Initial, Last)

Street

City, State, Zip Code

Phone Number ( ) - Email

Date of Birth - - Gender: ◯ Male ◯ Female Height: ft. in. Weight: lbs.
MM DD YYYY

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 - - Gender: ◯ Male ◯ Female Height: ft. in. Weight: lbs.
MM DD YYYY

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*

SPOUSE/DOMESTIC PARTNER

◯ Senior Plan ($400 – $6,000)

Monthly Benefit Amount*

Check Elimination Period for you and your spouse:

◯ 30 days ◯ 60 days ◯ 90 days ◯ 180 days

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

5 Please Select Your Desired Coverage

	You		Spouse/Domestic Partner	
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?	◯	◯	◯	◯

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

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

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

6 Please Complete the Following continued

	You		Spouse/Domestic Partner	
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 ◯

7 Please Complete the Following continued

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

	Member		Spouse/Domestic Partner	
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?	◯	◯	◯	◯
B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?	◯	◯	◯	◯
C. Colitis, ulcer, liver, kidney disease, 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?: _____				
Are there any medical complications?	◯	◯	◯	◯

Continued →

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)

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 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.

SIGN & DATE

X _____

Signature of Applicant

Date MM - DD - YYYY

SIGN & DATE

X _____

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.

PA-9357 (HLA) (CA)(2-12) 50206

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!

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