HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

GROUP DISABILITY INCOME INSURANCE

PERSONAL HEALTH APPLICATION

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

THE HARTFORD

adha AMERICAN DENTAL HYGIENISTS' ASSOCIATION™
100 YEARS OF LEADERSHIP IN ORAL HEALTH

Association: **American Dental Hygienists' Association**
P.O. Box 14533
Des Moines, IA 50306

Questions? **Call toll-free: 1-800-503-9230**
Email: customerservice.service@getamba.com

Policyholder (and Participating Organization):	Policy No.:	Certificate No. (Leave Blank):
American Dental Hygienists' Association	AGP-5879	

Member's Name (First, Middle Initial, Last):				☐ Male ☐ Female
Date of Birth: _____	Place of Birth (State/Country): _____	Social Security Number: _____	Height: ft. _____ in. _____	Weight: _____ lbs. (if currently pregnant, pre-pregnancy weight)

Street: _____ City: _____ State: _____ Zip Code: _____	Preferred Phone No.: _____ ☐ Cell ☐ Home ☐ Work ☐ Daytime ☐ Evening	Email: _____

Member's Occupation: _____ Specialty/Duties: _____ Annual Salary $: _____	☐ I am a current ADHA member. Member Number: _____

Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.
DI648E-AGP5879UWECA
54236/54237/1018/52247

***Spouse's Name** (First, Middle Initial, Last) if applying:				☐ Male ☐ Female
Date of Birth: _____	Place of Birth (State/Country): _____	Social Security Number: _____	Height: ft. _____ in. _____	Weight: _____ lbs. (if currently pregnant, pre-pregnancy weight)

Street: _____ City: _____ State: _____ Zip Code: _____	Preferred Phone No.: _____ ☐ Cell ☐ Home ☐ Work ☐ Daytime ☐ Evening	Email: _____

*Spouse's Occupation: _____ Annual Salary $: _____

*Spouse includes a partner in a registered domestic partnership under California law.

COVERAGE REQUESTED:

DISABILITY INCOME Minimum of $400 but not to exceed $6,000 (in $100 increments).

Member Coverage:

☐ $400 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $5,500 ☐ $6,000

Other $_____(in $100 increments)

Elimination Period: ☐ 60 days ☐ 90 days ☐ 180 days

***Spouse Coverage:**

☐ $400 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $3,500 ☐ $4,000 ☐ $4,500 ☐ $5,000 ☐ $5,500 ☐ $6,000

Other $_____(in $100 increments)

Elimination Period: ☐ 60 days ☐ 90 days ☐ 180 days

	MEMBER	*SPOUSE
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
Do you consume alcohol? If "yes", please indicate: Amount: Member: per weekday: _____ per weekend: _____ *Spouse: per weekday: _____ per weekend: _____	☐ Yes ☐ No	☐ Yes ☐ No

PLEASE COMPLETE THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:	MEMBER	*SPOUSE
1. In the past 7 years, have you been diagnosed or treated for:		
A. High blood pressure, coronary artery disease, heart attack or surgery, heart valve disease, heart failure, atrial fibrillation or other arrhythmia, blocked arteries, arteriosclerosis or atherosclerosis, deep vein thrombosis (DVT), peripheral, vascular disease, aneurysm, Stroke or transient ischemic attack (TIA), Heart Murmur or Heart disease?	☐ Yes ☐ No	☐ Yes ☐ No
B. Asthma, pneumonia, chronic bronchitis, sarcoidosis, cystic fibrosis, tuberculosis, chronic obstructive pulmonary disease (COPD) or emphysema, sleep apnea or Narcolepsy?	☐ Yes ☐ No	☐ Yes ☐ No
C. Kidney stones, chronic kidney disease, polycystic kidney disease, interstitial cystitis, benign prostatic hyperplasia, abnormal PAP smears, fibroids, endometriosis or menstrual disorder?	☐ Yes ☐ No	☐ Yes ☐ No
D. Depression, anxiety, schizophrenia, post-traumatic stress disorder (PTSD), Attention deficit hyperactive disorder (ADHD/ADD), personality disorder, obsessive compulsive disorder or bipolar disorder?	☐ Yes ☐ No	☐ Yes ☐ No
E. Infection or dysfunction of the central or peripheral nervous system, Alzheimer's, dementia, Parkinson's, Huntington's, amyotrophic lateral sclerosis (ALS), multiple sclerosis, neuropathy, syncope, migraine, seizures, epilepsy or paralysis?	☐ Yes ☐ No	☐ Yes ☐ No
F. Disease, injury or surgery of joint, ligaments, knee, back or neck including arthritis, spinal disc disorder, fibromyalgia, bursitis, spondylitis, muscular dystrophy, psoriasis or chronic fatigue syndrome/Fibromyalgia or chronic pain?	☐ Yes ☐ No	☐ Yes ☐ No
G. Ulcerative colitis, Crohn's, Hemochromatosis, Ulcer, diverticulitis, familial polyposis, Barrett's esophagus, Hepatitis A, Hepatitis B, Hepatitis C, Cirrhosis or pancreatitis?	☐ Yes ☐ No	☐ Yes ☐ No
H. Diabetes, anemia, thyroid, adrenal insufficiency, Cushing's or prolactinoma?	☐ Yes ☐ No	☐ Yes ☐ No
I. Impaired sight, glaucoma, macular degeneration, retinal detachment or Meniere's disease?	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 7 years, have you been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC*) or any other Disorder of the Immune System as defined below, excluding HIV tests and diagnosis?	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 12 months have you been confined in a hospital, nursing home, sanatorium or similar institution (excluding maternity)?	☐ Yes ☐ No	☐ Yes ☐ No
4. In the past 7 years have you been diagnosed or treated by a member of the medical profession for cancer? If "yes", indicate: Type of cancer diagnosed by your physician: / Date treatment completed:	☐ Yes ☐ No	☐ Yes ☐ No

5. In the past 7 years have you been diagnosed or treated by a member of the medical profession for seizures? If "yes", indicate: Type of seizure diagnosed by your physician: / Date of diagnosis/onset: Cause of seizures: / Frequency of seizures: Medication, dosage, date last taken: / Date of last seizure:	☐ Yes ☐ No	☐ Yes ☐ No
6. In the past 7 years have you been treated by any medical professional, surgeon, psychologist, psychiatrist or other practitioner, other than yourself if you are a physician, or a family member, for any reason not previously noted on this application?	☐ Yes ☐ No	☐ Yes ☐ No
7. In the past 7 years, have you been advised by a medical professional to have a medical test done or are you awaiting treatment for a medical condition?	☐ Yes ☐ No	☐ Yes ☐ No

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 professional's 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

AIDS Related Complex (ARC)* is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

Please read all items carefully and sign below.

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION
NOTICES, AGREEMENTS AND ACKNOWLEDGEMENTS

Notice

To the best of your knowledge, you are required to notify Hartford Life and Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date coverage is approved.

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company may contact you, through the mail or over the telephone:
1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, and copies of medical records which you have authorized us to review, and information obtained from MIB, Inc.

Agreements

Subject to any deferred effective date provision, I understand that coverage will not become effective until (a) the Company grants its underwriting approval; and b) at the time of payment of the first premium, I am living, and my insurability remains the same as that described in the application. I do not receive temporary or conditional insurance coverage just because I submit an application and paid my first premium. I agree that the Company may request whatever additional evidence of insurability it needs.

Representations

I have read all statements and answers in this application, and in any other application or medical form required by the 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.

Acknowledgement

I acknowledge that I am currently a member of Association and understand I must retain membership to be eligible for this insurance plan. I acknowledge that a copy of this application shall be attached to and form a part of any policy issued.

Authorization

I, an undersigned applicant, authorize Hartford Life and Accident Insurance Company, together with its affiliates, ("Company") to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

In the event that I cannot be reached via telephone, I authorize a representative of the Company to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that he or she is calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company by telephone.

☐ Yes, you may leave a message as indicated above. ☐ No, please do not leave a message.
(If not checked, you will not be contacted by phone.)

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize any employer, any health or benefits plan, physician, counselor, medical professional, hospital, clinic or medical facility, laboratory, MIB, Inc., pharmacy or pharmacy benefits manager, motor vehicle violation reporting agency, consumer reporting agency that possesses my protected Personal Health Information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me **(but excluding HIV and genetic testing)**, drug and alcohol use history, other insurance coverage or employment status to furnish such protected health information to the Company or its representative. The Company may only use information disclosed under this Authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

Acknowledgement

I acknowledge that I am currently a member of the Association and understand I must retain membership to be eligible for this insurance plan.

I authorize the Hartford Life and Accident Insurance Company to give information about me or my dependents to only those companies to whom I or my dependents have applied for Life and Health Insurance, the MIB, Inc., 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. This authorization expires two (2) years from the effective date of my coverage or my dependent's 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 or my authorized representative have a right to receive a copy of this form upon request.

PRE-EXISTING CONDITIONS LIMITATION

I/We understand that any diagnosed injury or sickness, for which I/we have received medical advice or treatment in the 1 year period prior to my/our effective date of coverage will not be covered until I/we have gone 1 year ending on or after my/our effective date of coverage without medical advice or treatment for that condition, or until 2 years 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.

Member's signature (Sign name in full) _____ Date _____
Required

***Spouse's signature** (if applying) _____ Date _____
Required Required

PREMIUM PAYMENT

I wish to pay my premiums: Monthly Quarterly Semi-annually Annually

Automatic Bank Withdrawal (Electronic Funds Transfer):

Name:_____ Banking Institution:_____

Routing Number:_____ Account Number:_____

Bank Account Type: _____ ☐Checking ☐Savings

I authorize the Administrator to initiate my regular payment from the bank account provided above. I understand that payment will be processed on or after the due date and will continue to be charged or deducted from my account unless I notify the Administrator otherwise in writing or my coverage ends. I also understand if corrections of the debit are necessary, this may involve an adjustment to my account.

Member's signature (Sign name in full) _____ Date _____
Required Required

***Spouse's signature** (if applying) _____ Date _____
Required Required

For residents of California: The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with the actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Return Completed Form Today to:
ADHA GROUP INSURANCE PROGRAM
P.O. Box 14533
Des Moines, IA 50306

QUESTIONS?
Call Toll Free:
1-800-503-9230
Email:
customerservice.service@getamba.com

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

This endorsement forms a part of the Group Insurance Application and Personal Health Application.

This endorsement becomes effective on January 1, 2023.

State Notice for applicants in California:
For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signed for Hartford Life and Accident Insurance Company

Kevin Barnett, *Secretary*

Jonathan Bennett, *President*

Domestic Partnership Affidavit

Name of Applicant _____

Name of Domestic Partner _____

The undersigned member and domestic partner, being of sound mind, hereby state the following:

1. That the undersigned member and domestic partner have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations and that this commitment is of at least six months duration and is expected to continue indefinitely.

2. That the undersigned member and domestic partner share a single permanent residence (attach one copy of evidence such as driver's license).

3. That the undersigned member and domestic partner are financially interdependent as demonstrated by at least two of the following (check all that apply and attach copy of evidence):

- ❑ Common ownership of a motor vehicle.
- ❑ Joint bank or credit accounts.
- ❑ Assignment of durable power of attorney in favor of one another.
- ❑ Common ownership of real estate or common leasehold interest in property.
- ❑ Joint ownership or holding of stocks, bonds, or other investments.
- ❑ Execution of will naming each other as executor and/or beneficiary.
- ❑ Designation as beneficiary under the other's retirement or pension benefits account.

4. That the undersigned member and domestic partner (check one):

- ❑ have filed a domestic partner declaration with the (City/Council/Borough) of_____ and that such domestic partner declaration remains in effect (attach copy of declaration).
- ❑ do not reside in a jurisdiction which provides for the registration of domestic partnership declarations.

5. That neither the undersigned member nor domestic partner would be able to affirm questions 1 through 4 above with respect to any person except the other.

6. That neither the undersigned member nor domestic partner has executed or filed a declaration or affidavit of domestic partner status with any other person within the past 12 months.

7. That the undersigned member and domestic partner are each no less than 18 years of age, and are under no legal disability which would prevent them from making this affidavit.

8. That neither the undersigned member nor domestic partner are now, or have been within the past six months, married to any other person, including common law marriage.

9. That the undersigned member and domestic partner are not related by blood in any degree which would prevent their marriage to each other.

The undersigned member and domestic partner represent that the statements made herein are true and correct to the best of their knowledge, information and belief. Member and domestic partner understand that these statements are given for the purpose of establishing their eligibility and understand that any misrepresentation, whether or not made with intent to deceive, may result in the ineligibility of the domestic partner for coverage under such policy, and in the voiding of such coverage. The member and domestic partner agree to furnish upon the Company's request evidence to substantiate any statement made herein, and that the Company may require the member and/or domestic partner, if living, to reaffirm all statements made herein periodically and/or when a claim is submitted. In the event any coverage is voided due to any misrepresentation herein, the Company's liability shall be limited to a return of any premiums paid on behalf of the domestic partner for any period of ineligibility.

Applicant's Signature_____ **Date**_____

Domestic Partner's Signature_____ **Date**_____