GROUP DISABILITY INCOME INSURANCE

PERSONAL HEALTH APPLICATION

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

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

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

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.
DI648E-AGP5879SIENJ
54236/54237/1018/52247

COVERAGE REQUESTED:

DISABILITY INCOME Minimum of $400 but not to exceed $4,000 (in $100 increments).

Member Coverage:

☐$400 ☐$1,000 ☐$1,500 ☐$2,000 ☐$2,500 ☐$3,000 ☐$3,500 ☐$4,000 Other $_____(in $100 increments)

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

	MEMBER
Is the Monthly Benefit Amount herein applied for equal to or less than 70% of your Pre-Disability Earnings minus any Other Income Benefits?	☐ Yes ☐ No
Do you consume alcohol? If "yes", please indicate: Amount: Member: per weekday: _____ per weekend: _____	☐ Yes ☐ No

PLEASE COMPLETE THE FOLLOWING:	MEMBER
1. In the past 5 years have you been diagnosed or treated for high blood pressure, cancer, tumor, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any disease or disorder of the glands, thyroid, any lung or respiratory disorder, liver, kidney or genitourinary disease or disorder, including hepatitis, alcohol or drug abuse or dependency, epilepsy, mental or nervous disorder, neurological impairment, bone, joint, back, muscle or connective tissue disorder, or Chronic Fatigue Syndrome? If "yes", indicate: Diagnosis by your physician: _____ Date of diagnosis: _____ Treatment including medication, dosage, date last taken: _____ Has the medical professional treating you for this condition released you from care?	☐ Yes ☐ No ☐ Yes ☐ No
2. Have you ever 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?	☐ 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

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

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.

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. I authorize the Company to request an investigative consumer report. I understand that an investigative consumer report commonly includes information regarding an applicant's character, general reputation, personal characteristics, and mode of living. I acknowledge that upon my written request, the Company will advise whether or not a consumer report was requested, and if so, the Company will provide the name and address of the consumer reporting agency to whom the request was made. I understand that I may contact the consumer reporting agency and request to inspect and receive a copy of the report. 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.

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 hereby acknowledge that I have read all statements and answers in this application, and in any other application or medical form required by the Company, and certify 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 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 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 authorize the Hartford Life and Accident Insurance Company to give information about me to any other insurance company to whom I may apply 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 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.

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 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 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

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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