GROUP LIFE INSURANCE APPLICATION

HARTFORD LIFE INSURANCE COMPANY
Hartford, Connecticut 06155

Section 1

Association Name:	American Speech-Language-Hearing Association	Policy No.: AGL-1281	Certificate No.: (Leave Blank)

Section 2

Proposed Insured's Name: (First, Middle Initial, Last)		❑ Male ❑ Female	Date of Birth (MM/DD/YYYY):
Street:			Height: _____ft. _____in.
City:	State:	Zip Code:	Weight: _____lb.
Preferred Phone No.: ( )	Proposed Insured's Occupation:		

Beneficiary - Print full name & relationship to you

Name:_____ Relationship:_____

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

Section 3

Spouse/Domestic Partner's Name: (First, Middle Initial, Last), if applying	❑ Male ❑ Female	Height: _____ft. _____in. Weight: _____lb.
Date of Birth (MM/DD/YYYY):	Place of Birth (State/Country):	

Section 4

Amount Desired: ($12,500 minimum up to $150,000 maximum in $12,500 increments)

Member: ❑ $150,000 ❑ $125,000 ❑ $100,000 ❑ $75,000 ❑ $50,000 ❑ $25,000
❑ $137,500 ❑ $112,500 ❑ $ 87,500 ❑ $62,500 ❑ $37,500 ❑ $12,500

Spouse/Domestic Partner: ❑ $150,000 ❑ $125,000 ❑ $100,000 ❑ $75,000 ❑ $50,000 ❑ $25,000
❑ $137,500 ❑ $112,500 ❑ $ 87,500 ❑ $62,500 ❑ $37,500 ❑ $12,500

Please indicate if request is for:

❑ New Coverage

❑ Change in Coverage

Member's Current benefit amount: $_____ Additional benefit requested: $_____ Total benefit: $_____

Spouse/Domestic Partner's Current benefit amount: $_____ Additional benefit requested: $_____ Total benefit: $_____

IF REQUEST IS TO CHANGE EXISTING COVERAGE PRINT ONLY ADDITIONAL AMOUNT DESIRED

CHILD COVERAGE: ❑ Yes ❑ No

If Dependent Coverage is desired, complete the following:		
Dependent Full Name	Relationship	Birth Date

Section 5

PLEASE COMPLETE THE FOLLOWING:	**Member YES/NO**	**Spouse/ Domestic Partner YES/NO**
In the last 2 years, have you or your Spouse/Domestic Partner been unable to perform the full-time duties of your occupation for 10 consecutive days, or if not employed, been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90 day period immediately preceding the date of this application for 10 consecutive days?	❑ ❑	❑ ❑
All questions are answered to the best of my knowledge and belief:		
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, kidney disease or disorder, or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive systems?	❑ ❑	❑ ❑
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?	❑ ❑	❑ ❑
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?	❑ ❑	❑ ❑

Section 6

If you answered "Yes" to any of the above medical questions, please explain the details below.			
Question Number and Condition	Name of Family Member	Dates	For any question answered "yes" please provide details, including dates, your physician's name, full address, phone number and fax number (Required for processing.)

(Attach sheet of paper if additional space is needed.)

Section 7

Please read carefully all items and sign below.

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

I/We hereby certify that I/we have read all statements and answers in this application, and in any other application or medical form required by Hartford Life 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 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 paid my 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 Insurance Company or its legal representative information about my/our or my/our dependent's 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 Insurance Company will use the above information to decide if and to what extent I/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 Insurance Company.

I/We authorize Hartford Life Insurance Company to give information about me/us to 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 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 my/our dependent's 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 of its contents shall form a part of my/our enrollment request for group benefits.

Section 8

Proposed Insured's signature (Sign name in full) _____ Date_____
Required Required

Spouse/Domestic Partner's signature (if applying) _____ Date_____
Required Required

Section 9

Please check "Yes" or "No" on the next line.
By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance?
You: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

Indicate how you wish to be billed:

❑ Automatic Monthly Check Withdrawal
❑ Semi-Annual Direct Bill
(If you select Automatic Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

TO APPLY:
Send this completed form to:
ADMINISTRATOR
ASHA GROUP INSURANCE PROGRAM
P.O. Box 10374
Des Moines, IA 50306-8812

QUESTIONS?
Call: 1-866-795-9340
E-Mail: customerservice.service@mercer.com

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HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK

IMPORTANT REPLACEMENT NOTICE

THIS NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY INSURANCE REGULATION NO. 60

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into a paid-up or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to contemplating a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you to decide whether the replacement is in your best interest.

I HAVE READ THE IMPORTANT REPLACEMENT NOTICE THAT ACCOMPANIED THIS APPLICATION.

Do you intend to replace, in whole or in part, any existing life insurance or annuity?
Yes _____No_____

Date: _____Signature of Applicant: _____

Date: _____Signature of Applicant: _____

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BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plan. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact the company's representative or your own legal advisor.

A beneficiary designation may be changed at any time upon written request.

Please note that a Power of Attorney (POA) may not have the authority to change a beneficiary.

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Doe	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Insured/Member) and dated.**

BENEFICIARY DESIGNATION

❑ Initial Beneficiary Designation(s) OR ❑ Change of all prior beneficiary designations(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group and direct that the insurance proceeds payable under the policy be paid as indicated below.

Insured/Member Name:	Date of Birth:	Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐
Insured/Member Address:		Telephone Number: ( )
Policyholder:		Policy Number:

NAMING YOUR LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact the company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, according to the terms under the policy.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state – Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse fo the Insured named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of the group life term and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Insured/Member's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Insured/Member: _____ **Date:** _____

Please note that a Power of Attorney (POA) may not have the authority to change a beneficiary.

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**_____

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AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ Date: _____

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Group Term Life Insurance Plan

For ASHA Members

Up to $150,000[1] in Coverage for You and Your Spouse/Domestic Partner … up to $75,000 available to use while you're still alive

Life Insurance … for your responsibilities.

The Living Benefits Life Insurance Plan can help protect your family's financial stability which you've worked so hard to achieve.

Why Buy Life Insurance? Throughout your life you've gained many responsibilities and commitments. Life insurance can help you keep the promises you made in several ways. The proceeds of a life insurance policy may be needed to help …

- pay off a mortgage or continue rent payments
- provide an education fund for your children
- pay off business debts or other financial obligations
- pay taxes on your estate
- pay large medical bills due to a prolonged illness
- provide money for other financial needs your survivors may face

The Living Benefits Life Insurance Plan is designed to help provide you and your family sound financial protection at reasonable group rates. If you are under age 65 you have the opportunity to apply for up to $150,000 of life insurance protection in $12,500 units for yourself and for your Spouse/Domestic Partner, and up to $1,100 for each of your eligible children. Plus, you can receive up to one-half of your chosen benefit before you die should you be diagnosed as Terminally Ill.

Take a positive step towards helping to secure your family's financial future and review the Living Benefits Life Insurance Plan today! Then complete the Application and return it with your first semi-annual premium payment.

Living Benefits Life — The Living Life Benefit!

Most people purchase life insurance to gain peace of mind in knowing that they are helping their families become financially secure when they die. With Living Benefits Life, members can gain added peace of mind for themselves and their families before they die should they become Terminally Ill. A Terminal Illness is a condition where your life expectancy is 12 months or less. This must be confirmed in writing by a physician licensed to practice in the United States, and supportive evidence may be required by the Insurance Company.

Treatment, nursing care, hospitalization, nursing home confinement, hospice care and other expenses associated with a Terminal Illness can cost thousands of dollars. Not only could a Terminal Illness cause large medical bills, it could also force your income to stop.

With the Living Life Benefit you may elect to receive up to one-half of the total benefit amount of your Group Term Life Insurance Plan prior to death if you are diagnosed as being Terminally Ill. (These living or "accelerated" benefits may be taxable, so please consult your personal tax advisor.) Then, the amount of your total benefit that is not used as part of your Living Life Benefit will be paid directly to your beneficiary upon your death.**

If you do not use the living or "accelerated" benefit provision of this Plan, your full benefit would be paid to your beneficiary upon your death. Your beneficiary will not have to pay federal income taxes on these benefits based on current tax laws (please consult a tax advisor for further information**).

The Living Life Benefit is a practical way to help complement your existing insurance plans including health, disability and life. It would pay you a valuable benefit at a time when high medical bills and loss of income could put your family's financial security at risk. And the benefits are paid directly to you in a lump sum payment for you to spend however you wish.

**This information is written in connection with the promotion or marketing of the matter(s) addressed in this material. The information cannot be used or relied upon for the purpose of avoiding IRS penalties. These materials are not intended to provide tax, accounting or legal advice. As with all matters of a tax or legal nature, you should consult your own tax or legal counsel for advice.

IMPORTANT FEATURES:

Reasonable Cost

Your premiums are affordable through the economies of centralized group administration.

Waiver of Premium for Disability

If you are Totally Disabled before you reach age 60 and remain disabled for nine consecutive months, your insurance will remain in force without further premium payments as long as you are disabled or until age 70. When your disability ends, premium payments resume.

Total Disability means a disability that is caused by bodily injury or disease which prevents you: from engaging in any occupation or profession for wage or profit; or if not employed, from engaging in the normal and customary activities of a person of like age and sex in good health.

Complete Coverage

Your insurance is payable in the event of death from any cause (except suicide during the first two years) ... at any time ... in any place. This coverage can also be maintained when you change employers.

Your Choice of Beneficiary

You may name anyone as your beneficiary. You may change your beneficiary at any time by writing the Insurance Administrator. Upon proof of death, your beneficiary receives the benefit in a lump sum or monthly installments, whichever the beneficiary wishes. You are automatically the beneficiary of your children's insurance. If you do not name a beneficiary the insurance amount will be paid to your survivors, in equal shares, to first your spouse/Domestic Partner; children; parents; brothers and sisters or to your estate.

Effective Date

Your coverage will become effective after your application is approved by The Hartford and the receipt of the first month premium has been received by the administrator. However, if on that date you cannot perform the normal duties of your type of work, your coverage will not begin until you have returned to Full-Time active employment or you are able to carry on all the normal and customary activities of a person of like age and sex in good health.

Eligibility

You and your Spouse are eligible for coverage if you are a member of the Association, under age 65. Your dependent children are also eligible for coverage if they are under 25 years of age and primarily dependent on you.

This coverage is available only for residents of the United States excluding ID, MD, MT, NH, OR and WV.

Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford***. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s), or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience.

Renewability

As long as you pay your premiums, you remain a member of the Association, and the Master Policy is not terminated by the Insurance Company, your coverage cannot be cancelled. Your insurance is renewable to age 90 (age 70 with respect to the Waiver of Premium benefit explained above). Your dependents are insured as long as your coverage remains in force, their premiums are paid and they continue to meet the eligibility requirements of the Plan. Children's coverage does not include the Living Life Benefit.

Conversion Rights

You may convert your group life insurance if your coverage ends for any reason except non-payment of premium, for up to the same amount of life insurance to any individual life policy, other than term, underwritten by the Insurance Company. Complete conversion rights are outlined in your Certificate.

Exclusion

Suicide while sane or insane (in Missouri while sane) is not covered during the first two years you are insured. During the first two years of coverage under the Policy an amount equal to the premium paid for coverage to the date of death will be paid.

YOUR SEMI-ANNUAL PREMIUM

Applicant or Spouse/Domestic Partner
PER $12,500 UNIT of COVERAGE

Age	Male	Female
Under age 30	$10.38	$ 6.90
30–34	11.52	9.18
35–39	16.08	12.60
40–44	26.40	19.50
45–49	46.02	28.80
50–54	74.70	42.60
55–59	113.88	64.38
60–64	181.68	98.88
65–69*	259.92	159.90
70–74*	244.80	203.22
75–79*	357.90	296.64
80–84*	269.64	223.62
85–89*	386.52	320.76

* For renewal only.

Rates are based on the attained age of the Insured Person and increase as you enter each new age category.

[1]Benefits reduce to 50% of original face amount at Age 70. The premium shown is per $6,250 benefit. Benefits reduce to 25% of original face amount at age 80. The premium shown is per $3,125 benefit.

Coverage terminates at age 90. Rates and/or benefits may be changed on a class basis only.

$1.60 rate covers each eligible dependent child, age 6 months to 25 years, for a benefit of $1,100 (under 6 months for a benefit of $500).

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

30-Day Free Look — you have 30 days to look over your plan of insurance and discuss it with your family and advisors. If for any reason you're not satisfied, you may return your certificate within 30 days of your effective date of coverage for a full refund, minus any claims paid.

Administered by:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
P.O. Box 10374
Des Moines, IA 50306-8812

Questions?
1-866-795-9340
www.slhadvisor.com

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

Underwritten by:

Hartford Life Insurance Company
Hartford, CT 06155

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

This brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the Hartford Life Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the Trustee for the Professional Association and Organization Insurance Trust.

Life Form Series includes SRP-1153, or state equivalent.

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NOTICE OF INSURANCE INFORMATION PRACTICES

To properly underwrite and administer your application for insurance coverage, we must collect certain information concerning your insurability. You are our most important source of information, but we may also contact other sources such as medical professionals and institutions, employers and other insurance companies. While all information regarding your insurability will be treated as confidential, in some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

INVESTIGATIVE CONSUMER REPORTS – NOT APPLICABLE TO RESIDENTS OF NEW YORK

As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. You have the right to send a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

PERSONAL HISTORY INTERVIEW

To provide you, our client, with the best possible service, we may also conduct what we call a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the application information is complete. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

MEDICAL INFORMATION BUREAU (MIB) PRE-NOTICE

Information regarding your insurability will be treated as confidential. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company, with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, or their reinsurers, may also release information from their files to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

ACCESS, CORRECTION AND DISCLOSURE

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Also, please be advised that personal and confidential information collected by us may, in certain circumstances, be disclosed to third parties without authorization. A notice providing further description of the circumstances under which information about you may be disclosed and the types of persons and organizations to whom it may be disclosed will be sent to you upon your written request. If you desire further information or access to your personal information, please send your written request to: Hartford Life Insurance Company or Hartford Life and Accident Insurance Company, 200 Hopmeadow St., Simsbury, CT 06089.

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