# GROUP DISABILITY INCOME INSURANCE APPLICATION


HARTFORD LIFE INSURANCE COMPANY
Hartford, Connecticut 06155


American Dental Hygienists' Association

**Section 1**

| Association Name: American Dental Hygienists' Association | Policy No.: AGP-5573 | Certificate No.: (Leave Blank) |
|---|---|---|

**Section 2**

| Member Name: | ❑ Male ❑ Female | Height: _____ft. _____in. Weight: _____lb. |
|---|---|---|
| Date of Birth (MM/DD/YYYY): | Age Last Birthday: | Place of Birth (State/Country): |
| Daytime Phone No.: ( ) | Business Telephone: ( ) | Email Address:_____ |
| Occupation: | | Basic Monthly Pay: $_____ |

| Home Address: Street: | City: | State: | Zip Code: |
|---|---|---|---|
| Business Address: Street: | | | |
| City: | State: | | Zip Code: |

Beneficiary – Print full name & relationship to you

Name:_____ Relationship:_____

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

**Section 3**

| Spouse's Name: (First, Middle Initial, Last), if applying | ❑ Male ❑ Female | Height: _____ft. _____in. Weight: _____lb. |
|---|---|---|
| Home Address: Street: | City: | State: Zip Code: |
| Date of Birth (MM/DD/YYYY): | Age Last Birthday: | Place of Birth (State/Country): |
| Spouse's Occupation: | | Basic Monthly Pay: $_____ |
| Daytime Phone No.: ( ) | | Business Telephone: ( ) |
| Business Address: Street: | | |
| City: | State: | Zip Code: |

**Section 4**

**COVERAGE REQUESTED:**

Member Coverage:
❑ New Coverage: Monthly Benefit Amount: $_____
❑ Change in Coverage:
Increase my Monthly Benefit Amount to: $ _____
❑ Change in Waiting Period:
Waiting Period: ❑ 60 days ❑ 90 days ❑ 180 days

Spouse Coverage:
❑ New Coverage: Monthly Benefit Amount: $_____
❑ Change in Coverage:
Increase my Monthly Benefit Amount to: $ _____
❑ Change in Waiting Period:
Waiting Period: ❑ 60 days ❑ 90 days ❑ 180 days

**Section 5**

Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company?
❑ Yes ❑ No If yes, give details:

| Name | Company | Monthly Benefit | Benefit Period | Waiting Period | To be replaced? Yes | To be replaced? No |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 25 hours per week) immediately before the date of this application? You: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

Is the Monthly Benefit Amount herein applied for equal to or less than 70% of your Basic Monthly Pay?
You: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

**Section 6**

| | PLEASE COMPLETE THE FOLLOWING: | Member Yes | Member No | Spouse Yes | Spouse No |
|---|---|---|---|---|---|
| | 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 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? | ❑ | ❑ | ❑ | ❑ |

**Section 7**

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. Sign and date additional sheet of paper.)

**SECTION 8**
**AUTHORIZATION**

I/We hereby certify that I/we have read or have had read to me/us 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 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/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 pay the 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 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 information to decide if and to what extent 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 or my/our dependents to any other insurance company to whom I/we or my/our dependents may apply for Life and Health Insurance, or any other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application or as required or authorized 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, 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 its contents shall form a part of my/our enrollment request for group benefits.

**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 12 month period prior to my/our effective date of coverage will not be covered until I/we have gone 12 months ending on or after my/our effective date of coverage without medical advice or treatment for that condition, or until 1 year 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.

**SECTION 9**

I wish to pay my premiums: ❑ Automatic Monthly Check Withdrawal ❑ Semi-Annual Direct Bill
(If you select Automatic Monthly Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

**SECTION 10**

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

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

**FRAUD WARNING STATEMENT**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.



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Send Completed Form To:

ADMINISTRATOR
ADHA GROUP INSURANCE PROGRAM
P.O. Box 10374
Des Moines, IA 50306-8812

**QUESTIONS?**
Call: 1-800-503-9230
customerservice.service@mercer.com

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# GROUP DISABILITY INCOME INSURANCE APPLICATION


HARTFORD LIFE INSURANCE COMPANY
Hartford, Connecticut 06155


**Section 1**

| Association Name: American Dental Hygienists' Association | Policy No.: AGP-5573 | Certificate No.: (Leave Blank) |
|---|---|---|

**Section 2**

| Member Name: | ❑ Male ❑ Female | Height: _____ft. _____in. Weight: _____lb. |
|---|---|---|
| Date of Birth (MM/DD/YYYY): | Age Last Birthday: | Place of Birth (State/Country): |
| Daytime Phone No.: ( ) | Business Telephone: ( ) | Email Address:_____ |
| Occupation: | | Basic Monthly Pay: $_____ |
| Home Address: Street: | City: | State: Zip Code: |
| Business Address: Street: | | |
| City: | State: | Zip Code: |

Beneficiary – Print full name & relationship to you

Name:_____ Relationship:_____

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

**Section 3**

| Spouse's Name: (First, Middle Initial, Last), if applying | ❑ Male ❑ Female | Height: _____ft. _____in. Weight: _____lb. |
|---|---|---|
| Home Address: Street: | City: | State: Zip Code: |
| Date of Birth (MM/DD/YYYY): | Age Last Birthday: | Place of Birth (State/Country): |
| Spouse's Occupation: | | Basic Monthly Pay: $_____ |
| Daytime Phone No.: ( ) | | Business Telephone: ( ) |
| Business Address: Street: | | |
| City: | State: | Zip Code: |

**Section 4**

**COVERAGE REQUESTED:**

Member Coverage:
❑ New Coverage: Monthly Benefit Amount: $_____
❑ Change in Coverage:
Increase my Monthly Benefit Amount to: $ _____
❑ Change in Waiting Period:
Waiting Period: ❑ 60 days ❑ 90 days ❑ 180 days

Spouse Coverage:
❑ New Coverage: Monthly Benefit Amount: $_____
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❑ Change in Waiting Period:
Waiting Period: ❑ 60 days ❑ 90 days ❑ 180 days

**Section 5**

Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company?
❑ Yes ❑ No If yes, give details:

| Name | Company | Monthly Benefit | Benefit Period | Waiting Period | To be replaced? Yes | To be replaced? No |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 25 hours per week) immediately before the date of this application? You: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Basic Monthly Pay minus any other Income Benefits?
You: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

**Section 6**

| | PLEASE COMPLETE THE FOLLOWING: | Member Yes | Member No | Spouse Yes | Spouse No |
|---|---|---|---|---|---|
| | 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 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? | ❑ | ❑ | ❑ | ❑ |

**Section 7**

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. Sign and date additional sheet of paper.)

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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 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 information to decide if and to what extent 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 or my/our dependents to any other insurance company to whom I/we or my/our dependents may apply for Life and Health Insurance, or any other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application or as required or authorized 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.

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(If you select Automatic Monthly Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

**SECTION 10**

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

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

**FRAUD WARNING STATEMENT**

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Des Moines, IA 50306-8812

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customerservice.service@mercer.com

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# 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 Disability Income Insurance Plan

American Dental Hygienists' Association

**DEVELOPED FOR YOUR ASSOCIATION**

## THIS PLAN HELPS PROVIDE AN INCOME WHEN YOU CAN'T WORK

If a covered disabling Sickness or Injury suddenly took away your ability to work and as a result also took away your ability to earn a paycheck . . . how would you continue to afford the living expenses you must now pay? With the Group Disability Income Plan sponsored by your association, a portion of your income would continue in the form of a monthly benefit that you select. Don't let a disability rob you of your income. Help protect your finances with the Group Disability Income Plan.

## WHO CAN APPLY

All Actively-at-Work (at least 20 hours per week) members and/or spouses/domestic partners under age 60, who reside in New York, may apply for this coverage. Spouse cannot be legally separated or divorced from you.

## HOW THIS PLAN WORKS

You select either **PLAN I** (which pays to a maximum of five years if you are totally Disabled due to a covered Injury and to a maximum of one year if you are Totally Disabled due to a covered Sickness), or **PLAN II** (which pays up to age 65 if you are Totally Disabled due to a covered Injury or Sickness). Under both plans, you have a choice of a 60, 90 or 180-day Waiting Period for benefits to begin.
For Plan I: If Total Disability occurs at or after age 64, benefits are paid for a maximum of 1 year. For Plan II: If Total Disability occurs at or after age 63, benefits are paid to a maximum of 2 years.

## YOU CAN SELECT FROM $600 TO $6,000 IN MONTHLY BENEFITS

You select the monthly benefit you wish to receive ranging from $600 to $4,000 per month (in $100 increments) for Plan I or up to $6,000 for Plan II. For Plan I, the Monthly Benefit you select should not exceed 70% of your Basic Monthly Pay. For Plan II, your Monthly Benefit should not exceed 60% of your Basic Monthly Pay. For Plan II, your actual monthly benefit amount at claim will be the lesser of: a) the benefit amount you selected, or b) 65% of your Basic Monthly Pay less any Other Income Benefits you may receive.

## IMPORTANT PLAN FEATURES

### Managed Disability Approach

The Managed Disability approach encourages a healthy lifestyle through prevention and wellness programs. When an individual becomes disabled, they are helped with rehabilitation and motivation to return to work as soon as reasonably possible.

### Rehabilitative Employment Benefit

A vocational rehabilitation program is available with staff nurses and specially trained counselors. Each individual rehabilitation program is custom tailored to each claimant's needs. Our counselors use skills assessment, job and transferable skills analysis, job modification, vocational testing, job placement assistance and retraining.

### Successive and Concurrent Disability Limitations

You would receive your selected benefit for disabilities which are recurrent in nature. Successive periods of the same or related disabilities are payable as new benefit periods (eligible for new maximum durations) when separated by six consecutive months of full-time active employment. Periods of disability, if due to the same or related medical causes and separated by fewer than six months while you are Actively-at-Work, are considered a single period of disability. Periods of disability from entirely unrelated causes are considered separate periods of disability. Benefits during any Period of Disability as the result of: more than one Sickness; or more than one Injury; or both Sickness and Injury; will be considered the same as if the Disability resulted from only one cause.

## EFFECTIVE DATE

Your insurance will become effective on the first of the month following the date of approval of your application, provided the required premiums are paid. If you are to become covered under the Policy; or covered for increased benefits under the Policy and you are not Actively-at-Work on the date your coverage is to become effective, you will not be covered until the first day of the month on or next following the date you are Actively-at-Work. 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 and at no expense to you.

## SATISFACTION GUARANTEED

When you receive your Certificate of Insurance, review it carefully. If you are not completely satisfied with the terms of your coverage, simply return your Certificate within 30 days and any premiums that have been paid will be promptly refunded in full, minus any claims paid.

## IMPORTANT DEFINITIONS

### Total Disability

You'll receive own-occupation protection for 2 years; which means you qualify for benefits if you cannot perform the substantial and material duties of your own regular occupation. Thereafter, the definition of Total Disability is the continuous inability to perform any and every occupation for which you are reasonably suited in terms of education, training or experience. However, for Plan II, if you are Totally Disabled due to mental or nervous disorders, alcoholism or drug abuse, the maximum payment period will be reduced to 2 years during your lifetime unless you are Confined in a hospital or other institution licensed to provide care and treatment for that disability.

### Partial Disability

A Partial Disability is a disability that (1) immediately follows a period of Total Disability; and (2) prevents you from engaging in active employment for more than four hours per day. Benefits equal to 50% of your monthly disability benefit will be paid for Partial Disability for up to a maximum of six months or as long as Partial Disability exists or until the maximum period for the disability is exhausted, whichever occurs first.

### Basic Monthly Pay

a.) If self-employed, Your net income after the deduction of business expenses for the Calendar Year immediately preceding the Total Disability, or

b.) If not self-employed, Your average monthly pay or rate of pay (not counting dividends or overtime payment) for the 12 months immediately preceding the Total Disability.

### Other Income Benefits

The actual benefit you receive at the time of your claim may be different, depending upon your income, offsets for Other Income Benefits and other variables. Other Income means the amount of any benefit for loss of income that you or your family receive or are eligible to receive from Social Security Disability Income or similar plans; Worker's Compensation or occupational disease laws or similar laws; group, association, union or other organizational coverage; employer-related individual policies; governmental laws or programs that provide disability or unemployment benefits as a result of your job with any employer; disability coverage under any employer's retirement plan; damages or settlements for income loss; and no-fault automobile insurance plans.

Other Income Benefits also include retirement benefits from retirement plans that are wholly or partially funded by employer contributions, unless you were receiving them prior to becoming disabled or you immediately transfer the payments to another plan qualified by the U.S. Internal Revenue Service for the funding of a future retirement.

Finally, Other Income Benefits include retirement benefits you or your family receives from Social Security or similar plans, unless you were receiving them prior to becoming disabled.

## CONVENIENT PAYMENT OPTIONS

You are able to choose between two premium payment options, whichever one best suits your needs:

**Option 1:** Automatic Monthly Check Withdrawal. Your premium will be automatically deducted from your checking account on a monthly basis. This not only saves you time, but you don't have to worry about missing a payment.

**Option 2:** Semi-Annual Direct Bill.

## TERMS OF COVERAGE

### Exclusions and Limitations

This Policy does not cover: intentionally self-inflicted Injury, suicide or attempted suicide; pregnancy or childbirth, except Complications of Pregnancy; any Sickness contracted or Injury sustained as the result of war or act of war, whether declared or not; any Injury sustained while riding on, boarding or alighting from, any aircraft: a) as a pilot, crew member or student pilot; b) operated by any military authority (land, sea or air), unless it is a Military Transport Aircraft used for transport and operated by the United States Military Air Mobility Command (AMC) or an AMC type service of a national government recognized by the United States; or c) being used for tests, experimental purposes, stunt flying, racing or endurance tests; the commission of a felony by you; Sickness contracted or Injury sustained while on full time active duty as a member of the Armed Forces (land ,water, air) of any country or international authority. We will refund the pro rata portion of any premium paid for you while you are in the Armed Forces on full-time active duty for a period of two months or more. Written notice must be given to us within 12 months of the date you enter the Armed Forces.

### Pre-Existing Conditions Limitation:

During the first 12 months of coverage, losses incurred for Pre-Existing Conditions are not covered.

Pre-Existing Condition means any Injury or Sickness including pregnancy, diagnosed or undiagnosed, for which you have received medical care within the 12-month period prior to your coverage effective date or the date of an increase in coverage. During that time, benefits for all other accidents or illnesses will be paid under the policy provisions. You are urged to consider this limitation before dropping any coverage you may have until the waiting period is over.

**Termination of Coverage**

Coverage continues as long as: you remain an association member; you pay your premiums on time; you remain Actively-at-Work (except by reason of disability covered by this plan); the Master Policy is in effect; and, you remain under 65 (Plan I) or under 70 (Plan II). Your dependent's coverage will remain in effect as long as your coverage is active, premiums are paid, and they meet the eligibility requirements.

**Waiver of Premium (Plan II only)**

If you become Totally Disabled before age 60, and the disability continues and for more than 6 consecutive months, you won't have to pay your premiums for as long as the disability lasts and benefits are payable.

**Semi-Annual Premiums per $100 of Monthly Benefit Amount**

**Plan I = 5 Year Accident/ 1 Year Sickness**

| Insured Person's Age | 60 days Waiting Period | 90 days Waiting Period | 180 days Waiting Period |
|---|---|---|---|
| Under 30 | $3.15 | $1.76 | $1.59 |
| 30-34 | $3.62 | $2.03 | $1.83 |
| 35-39 | $4.49 | $2.45 | $2.21 |
| 40-44 | $5.79 | $3.18 | $2.87 |
| 45-49 | $7.77 | $4.55 | $4.10 |
| 50-54 | $11.00 | $6.77 | $6.09 |
| 55-59 | $12.74 | $8.48 | $7.63 |
| 60-64* | $15.50 | $10.35 | $9.32 |

**Plan II = To Age 65**

| Insured Person's Age | 60 days Waiting Period | 90 days Waiting Period | 180 days Waiting Period |
|---|---|---|---|
| Under 30 | $3.20 | $1.63 | $1.47 |
| 30-34 | $3.96 | $2.00 | $1.80 |
| 35-39 | $5.35 | $2.74 | $2.47 |
| 40-44 | $7.97 | $4.41 | $3.97 |
| 45-49 | $11.60 | $7.26 | $6.53 |
| 50-54 | $17.38 | $11.53 | $10.38 |
| 55-59 | $16.53 | $11.80 | $10.62 |
| 60-64* | $13.43 | $8.70 | $7.83 |
| 65-69* | $13.86 | $8.66 | $7.80 |

Premiums apply at age when insurance becomes effective and at attained age on renewal dates. Rates and/or benefits in this brochure will not be changed unless they are changed for all insureds in your classification.

*For renewal purposes only—only those under age 60 may enroll.

**TO COMPUTE YOUR PREMIUM:** Multiply the premium listed for your age group by the number of $100 units of monthly coverage you select.

If you select the automatic monthly check withdrawal billing option and want to figure out your monthly premium, divide the premium listed for your age group by 6. Then take that total and multiply by the number of $100 units of Monthly Benefit you select.

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.

The monthly benefit amount you select may not exceed 70% for Plan I or 60% of your Basic Monthly Pay excluding bonuses, dividends and overtime pay for Plan II.

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

## It's Easy to Apply!

1. Complete, date and sign the Application. If your spouse is also applying, please complete the form and sign where indicated. If your domestic partner is applying, please complete and sign Domestic Partner Affidavit Form and return with your Application.
2. **Send no money now.** You will be billed when your application is approved and your Certificate is issued.
3. Mail your completed Application for approval to:

MERCER
MAKE TOMORROW, TODAY

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

**Administered by:**

MERCER
MAKE TOMORROW, TODAY

P.O. Box 10374
Des Moines, IA 50306-8812

**Questions?**
1-800-503-9230
www.adhainsurance.com

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

**Underwritten by:**

THE HARTFORD

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 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 Policyholder Educational Profession or America Group Insurance Trust. This program may vary and may not be available to residents of all states.

Disability Form Series includes SRP-1311, 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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