# GROUP TERM LIFE INSURANCE APPLICATION

**Hartford Life Insurance Company**
**Hartford, Connecticut 06155**

Please Print. Use Dark Ink. Do Not Erase. Initial All Changes. For Office Use: h w

| Association Name: American Occupational Therapy Association | Policy No.<br>AGL-1550 | Certificate No. (Leave Blank) | |
|---|---|---|---|
| Proposed Insured's Name (First, Middle Initial, Last) | ❑ Male<br>❑ Female | Date of Birth: | Height: _____ft. _____in.<br>Weight: ______lb. |
| Street<br>City State Zip Code | Phone No.<br>( ) | E-mail<br>Address: __________________ | |
| Proposed Insured's Occupation | | | |
| Beneficiary – Print full name & relationship to you<br>Name ______________________ Relationship ______________________ | | | |
| The Proposed Insured will be the beneficiary for any Dependent Coverage desired. | | | |
| Spouse/Domestic Partner's Name (First, Middle Initial, Last), if applying | ❑ Male<br>❑ Female | Date of Birth: | Height: _____ft. _____in.<br>Weight: ______lb. |
| Street<br>City State Zip Code | Phone No.<br>( ) | E-mail<br>Address: ______________________ | |
| Beneficiary – Print full name & relationship to you<br>Name ______________________ Relationship ______________________ | | | |

Amount Desired ($50,000 minimum up to $250,000 maximum in $50,000 increments)

Please indicate if request is for: ❑ New Coverage

**Member:** ❑ $ 50,000 ❑ $100,000 ❑ $150,000 ❑ $200,000 ❑ $250,000

**Spouse/Domestic Partner:** ❑ $ 50,000 ❑ $100,000 ❑ $150,000 ❑ $200,000 ❑ $250,000

The Spouse/Domestic Partner may not be covered under a Plan with benefits greater than 100% of the Member's Plan.

❑ 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: $___________

Child(ren) Coverage ❑ Yes ❑ No

The child benefit can be $1,000 to $5,000 in $1,000 increments. $____________

If Dependent Coverage is desired, complete the following:

| Full Name | Relationship | Birth Date | Height | Weight |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

At any time during the past 12 months to the present, has anyone proposed for coverage smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff? Member ❑ Yes ❑ No Spouse/Domestic Partner ❑ Yes ❑ No

| | Member | Spouse/ Domestic Partner |
|---|---|---|
| PLEASE COMPLETE THE FOLLOWING: | YES/NO | YES/NO |
| 1. 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? | ❑ ❑ | ❑ ❑ |
| 2. 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 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? | ❑ ❑ | ❑ ❑ |
| 3. 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 have you been confined or treated in any hospital, sanatorium or similar institution? | ❑ ❑ | ❑ ❑ |

If you answered "Yes" to any of the above medical questions, please explain the details below.

| Question Number and Condition | Name of Family Member | For any question answered "yes" please provide your physician's name, full address and phone number (Required for processing) |
|---|---|---|
| | | |
| | | |
| | | |

(Attach sheet of paper if additional space is needed.) Please read carefully all items and sign below.

Form SRP-1153 AP (D) (HL)

## AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

I hereby certify that 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. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs. Subject to the deferred effective date provision, I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and paid my first premium. I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; Medical Information Bureau, Inc.; or employer; to give Hartford Life Insurance Company or its legal representative information about my or my dependent's physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status.
Hartford Life Insurance Company will use the above information to decide if and to what extent I or my dependents are eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to the Hartford Life Insurance Company.
I authorize the Hartford Life Insurance Company to give information about me or my dependents to any other insurance company to whom I or my dependents may apply for Life and Health Insurance, the Medical Information Bureau, 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 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 have a right to receive a copy of this form upon request. I certify that I have received the Notice of Insurance Information Practices.

Member's signature (Sign name in full)________________________________________ Date ________________________

Spouse/Domestic Partner's signature (if applying)_________________________________ Date ________________________

**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?
Member: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

**STATE NOTICE**

Any person who includes any false or misleading information on an application or filing a claim for an insurance policy is subject to criminal and civil penalties. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, penalties may include imprisonment, fines, denial of insurance, and civil damages.

Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If while in the state of Florida, a person knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, the person is guilty of a felony in the third degree. 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, misleading or deceptive 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 be subject to substantial civil and/or criminal penalty where and to the extent allowed by state law.

Form SRP-1153 AP (D) (HL)

LI648E-1550
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**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:
AOTA GROUP INSURANCE PROGRAM
P.O. BOX 10374
Des Moines, IA 50306-8812

**QUESTIONS?**
Call: 1-800-503-9230
E-Mail: 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 Term Life Insurance Plan
# (with Living Benefit Feature)

The American Occupational Therapy Association, Inc.

## FOR AMERICAN OCCUPATIONAL THERAPY ASSOCIATION MEMBERS

### Read on for 2 ways you can get more protection for less…

**1. Your Association's Group Rates**

Your Association has made arrangements with Hartford Life Insurance Company to offer Group Term Life Insurance to eligible members under age 65.

Due to your Association's mass-purchasing power, this plan is available at economical group rates.

**2. Lower Rates for Non-Smokers*!**

If you haven't used tobacco products in the past 12 months, you're eligible for the non-smokers' rates. As shown in the rate chart that is inside, this varies by age.

*A non-smoker is one who has not smoked cigarettes, cigars or a pipe, or used chewing tobacco, nicotine chewing gum or snuff during the 12 months before submitting an application for life insurance.

**Even if you have some Life Insurance, you should consider applying!**

Do you have enough life insurance? If you were to pass away, would your loved one have enough money to pay your "final expenses," the mortgage or rent payments, car payments, other financial obligations, living expenses, education expenses, and all the rest? Don't pass up this opportunity to help provide a measure of financial security—$50,000 to $250,000—for your family, at the affordable group rates available to association members.

**You're Eligible to Apply if You're Under Age 65.**

Each member under age 65, Actively-at-Work for at least 30 hours per week is eligible to apply for up to $250,000 of coverage.

This coverage is available only for residents of the United States excluding AK, CO, ID, LA, MD, ME, MI, MN, MT, NV, NM, NY, OH, OR, SC, SD, TX, VT, WA and WV.

**Exclusions**

During the first 2 years of coverage (or following an increase in coverage) the benefit for death due to suicide while sane or insane will be limited to a refund of premium paid. Your beneficiary can be any person(s) or institution(s) you name.

**Protection for your Family!**

Coverage is available for your lawful Spouse/Domestic Partner, under age 65, from $50,000 to $250,000. Your Spouse/Domestic Partner's premium is based on your age. Spouse/Domestic Partner's coverage is available only if you are insured and may not exceed your amount of insurance. Benefit amount restrictions for Spouse/Domestic Partner may apply in some states.

A Spouse can not be legally separated or divorced from the member. You may also insure each of your dependent children (from 15 days old to age 23) for one monthly premium of 29¢ per $1,000 of coverage to a maximum of $5,000, no matter how many children you have. Children 15 days to 6 months can be covered for $250.

**Your Coverage is Renewable to Age 70**

Your insurance cannot be cancelled, up to age 70, as long as your premiums are paid when due, you continue your Association membership, you are not on full-time active duty in the Armed Forces and the Master Policy remains in force. Coverage terminates on the premium due date coinciding with or following your 70th birthday. Dependent coverage terminates when your coverage ends, when you discontinue the payment of premiums, or when dependents no longer satisfy eligibility requirements.

**Effective Date of Coverage**

When your application is approved by the insurer, your insurance will become effective as of the first of the month coinciding with or following approval and receipt of the first month of premium. However, if on that date you are not Actively-at-Work, you will not be so covered until the first day you are Actively-at-Work. However, should the Effective Date be a non-work day, insurance will still become effective on that date if you are otherwise Actively-at-Work on the last preceding scheduled work day.

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.

**Waiver of Premium if Totally Disabled**

Should you become Totally Disabled prior to age 60, and your disability continues for at least six consecutive months while insured, your coverage will continue without premium payments while you continue to be disabled. We'll also waive these premiums for your Spouse/Domestic Partner and covered dependents as long as you are unable to work and remain Totally Disabled. Once a disability ends, premium payments must resume.

Totally Disabled means your disability which begins before your 60th birthday, while you are covered under the policy, 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) and which has existed continuously for a period of at least six months.

### Life Insurance Conversion Right

If coverage terminates for any reason, except for non-payment of premium or reaching the maximum age, you and/or your covered dependents may be eligible to convert the life insurance to an individual policy, underwritten by The Hartford***. The conversion opportunity is limited when coverage terminates due to group policy termination. Details are in your Certificate of Insurance.

### Accelerated Death Benefit: "Living Benefit Feature"

The plan permits you and, if insured, your Spouse/Domestic Partner to take advantage of up to 50% of the death benefit or $125,000, whichever is less, prior to death provided the insured has been diagnosed by two physicians to be Terminally Ill, with life expectancy of less than 12 months. These funds can be used for any reason—for medical expenses, to pay off a mortgage, or just to make the final months more comfortable for the insured. The balance of the death benefit would go to the assigned beneficiary. Receipt of accelerated benefits may be taxable. 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.

### About Your Premiums

The monthly premiums shown below are for your choice of $50,000, $100,000, $150,000, $200,000, or $250,000 in coverage. Spouse/Domestic Partner's premiums are based on the member's attained age. Premiums increase as the member enters a new age bracket. The benefit amount remains constant. Rates and/or benefits may change on a class basis.

## 2 Ways to Pay!

If you choose to pay by Automatic Monthly Check Withdrawal, please complete the request on the application. The premium amount will automatically be deducted from your checking account each month. If you choose to pay by Semi-Annual Direct Bill, multiply your monthly premium by 6. You will be mailed a bill after your application has been accepted.

**SEND NO MONEY NOW!**

You are not required to send any money until your application is approved. You will be billed on a semi-annual basis later.

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.

**Living Benefit Term Life Insurance Plan–Monthly Premiums**

**Standard Rates**

| Member's Age | $50,000 | $100,000 | $150,000 | $200,000 | $250,000 |
|---|---|---|---|---|---|
| Under 30 | $4.40 | $5.28 | $7.92 | $10.56 | $13.20 |
| 30–34 | 5.28 | 7.04 | 10.56 | 14.08 | 17.60 |
| 35–39 | 7.20 | 10.88 | 16.32 | 21.76 | 27.20 |
| 40–44 | 11.76 | 20.00 | 30.00 | 40.00 | 50.00 |
| 45–49 | 18.56 | 33.60 | 50.40 | 67.20 | 84.00 |
| 50–54 | 29.08 | 54.64 | 81.96 | 109.28 | 136.60 |
| 55–59 | 45.52 | 87.52 | 131.28 | 175.04 | 218.80 |
| 60–64 | 68.96 | 134.40 | 201.60 | 268.80 | 336.00 |
| 65–69* | 112.00 | 220.56 | 330.84 | 441.12 | 551.40 |

**Non-Smoker Rates**

| Member's Age | $50,000 | $100,000 | $150,000 | $200,000 | $250,000 |
|---|---|---|---|---|---|
| Under 30 | $3.68 | $3.92 | $5.88 | $7.84 | $9.80 |
| 30–34 | 4.40 | 5.28 | 7.92 | 10.56 | 13.20 |
| 35–39 | 5.60 | 7.76 | 11.64 | 15.52 | 19.40 |
| 40–44 | 9.12 | 14.72 | 22.08 | 29.44 | 36.80 |
| 45–49 | 14.36 | 25.20 | 37.80 | 50.40 | 63.00 |
| 50–54 | 23.48 | 43.44 | 65.16 | 86.88 | 108.60 |
| 55–59 | 37.48 | 71.44 | 107.16 | 142.88 | 178.60 |
| 60–64 | 58.48 | 113.44 | 170.16 | 226.88 | 283.60 |
| 65–69* | 98.00 | 192.24 | 288.36 | 384.48 | 480.60 |

**Spouse/Domestic Partner Coverage****
(from $50,000 – $250,000)

| Per $10,000 Unit | |
|---|---|
| Under 30 | $1.40 |
| 30–34 | 1.75 |
| 35–39 | 2.37 |
| 40–44 | 3.50 |
| 45–49 | 5.52 |
| 50–54 | 8.75 |
| 55–59 | 13.57 |
| 60–64 | 18.90 |
| 65–69* | 30.80 |

*For renewal only.

Children's coverage: 29¢ monthly per $1,000 of coverage to a maximum of $5,000.

Rates are based on member's attained age and will increase as the member enters a new age bracket. Rates and benefits depicted are subject to change, but will not be changed more frequently than once in a 12-month period.

**Spouse/Domestic Partner rates are shown in $10,000 units. To determine your monthly rate, multiply the rate shown above by the number of $10,000 units you are applying for.

A non-smoker is one who has not smoked cigarettes, cigars or a pipe, or used chewing tobacco, nicotine chewing gum or snuff during the 12 months before submitting an application for life insurance.

**Administered by:**

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

**Questions?**
Phone: 1-800-503-9230
www.aotainsurance.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 policyholder Trustees of the Qualified Association and Organization Trust.

LI648P-1550

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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