Application for Group Disability Income Insurance

Hartford Life Insurance Company
Hartford, CT 06155

Policyholder Name: Minnesota Society of Certified Public Accountants
Group Policy Number: AGP-5182

Name: ____
Last First MI

Add 1: ____

Add 2: ____

City, St., Zip: ____________________________________

Are you a: ❑ Member ❑ Employee

If Employee indicate employer's name and address:

____

____

____

Member/Employee: Sex ❑ Male ❑ Female

Height _____ft. ______in. Weight_________lb.

Date of Birth _______/______/___________
(MM/DD/YYYY)

Place of Birth (City, State) ______________________________

(Country) ______________________________

Daytime Phone Number (_____)__________________________

E-Mail Address ____________________________________

Spouse Information (Complete if applying for spouse insurance.):

____
Last Name First Name MI

Sex ❑ Male ❑ Female

Height _____ft. ______in. Weight_________lb.

Date of Birth _______/______/___________
(MM/DD/YYYY)

Place of Birth (City, State) ______________________________

(Country) ______________________________

Daytime Phone Number (_____)__________________________

E-Mail Address ____________________________________

PLAN & BENEFIT SELECTION

Check your Monthly Benefit Amount: ❑ $500 ❑ $1,000 ❑ $2,000 ❑ $3,000 ❑ $4,000
❑ Other_______________

Check your Payment Period:

❑ **Plan A**
❑ **Plan B**

Check your Waiting Period:
❑ 30 days ❑ 90 days ❑ 180 days

Disability Insurance now being applied for may not exceed 66 2/3% of your monthly salary (exclusive of bonus, commissions, dividends, and overtime pay) minus any other disability income coverage you have in force.

BE SURE TO COMPLETE ALL INFORMATION AND SIGN REVERSE SIDE

FORM PA-9199

29900/29901/ 1018/52247

PLEASE COMPLETE THE FOLLOWING:

To be eligible for coverage, you must have been actively engaged in the full-time duties of your occupation for the last 90-day period immediately before the date of this application.

	MEMBER	SPOUSE
1. During the last 5 years, have you been diagnosed or been treated for cancer, tumor, high blood pressure, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any disease or disorder of the glands, any lung or respiratory disorder, liver, kidney or genitourinary disorder, alcohol or drug dependency, mental or nervous disorder, bone, joint, back, muscle or connective tissue disorder, or chronic fatigue syndrome?.	❑ Yes ❑ No	❑ Yes ❑ No
2. Have you ever been diagnosed or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)* or any other immune deficiency disorder (see reverse for complete definition)?.	❑ Yes ❑ No	❑ Yes ❑ No
3. Have you been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity)?.	❑ Yes ❑ No	❑ Yes ❑ No

Please review your answer to these questions to be sure that you have answered them fully and truthfully. A misrepresentation on these questions could void your coverage. Answering "Yes" to any of these questions disqualifies you from acceptance for coverage at this time.

I understand that my coverage will become effective after approval by the Company and receipt of the first payment of premium. By signing this application, I acknowledge that the Application is true and accurate for each person to be insured.

I further understand that any condition that is: excluded; or limited by the policy will not be covered under this policy at any time. I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 months period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, provided that the condition is not specifically excluded or limited by the policy.

By signing below, I acknowledge that I have read and agree to all terms.

Signature of Member ____ **Date** ______________________
Signature required to activate coverage

Signature of Spouse ____ **Date** ______________________
(if applying) *Signature required to activate coverage*

CERTIFICATION and AUTHORIZATION

I hereby certify that I have read all statements and answers in this application and that they are full, complete and true to the best of my knowledge and belief. I understand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the coverage, within the contestable period if such misrepresentation materially affects acceptance of the risk. I understand that coverage will not become effective until The Hartford[1] grants its underwriting approval. I agree that subject to the deferred effective date provision that no insurance coverage shall become effective unless: a) The Hartford grants its underwriting approval; and b) at the time of payment of the first premium, I am living, and my insurability remains the same as that described in the application. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium. I certify that I have received the Notice of Insurance Information Practices.

I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; consumer reporting agency; Medical Information Bureau, Inc., or employer; to give The Hartford or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status. The Hartford will use the information to decide if and to what extent I am 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. I authorize The Hartford to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I 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 understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my coverage or, if no coverage has been issued, one (1) year from the date of this application. I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request.

[1]The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing company Hartford Life Insurance Company. The issuing company is shown on the face page of this application.

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

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.

Indicate how you wish to be billed: ❑ Automatic Monthly Check Withdrawal ❑ Semi-Annual Direct Bill
(If you select Automatic Monthly Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

To Apply:
Send this completed form to:
MNCPA GROUP INSURANCE PROGRAM
P.O. Box 10374
Des Moines, IA 50306-8812

QUESTIONS?
1-800-732-8350
customerservice.service@mercer.com

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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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Long-Term Disability Income Insurance Plan

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

If a covered disabling Injury or Sickness 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 Long-Term Disability Income Insurance Plan sponsored by your association, your income would continue in the form of a monthly benefit that you select. Don't let a disability rob you of your income.

WHO CAN APPLY?

Members, their legal spouse and members' employees who are Actively-at-Work (at least 30 hours per week), are under age 60 may apply for this coverage.

This coverage is available only for residents of the United States excluding ID, ME, MT, NM, NY, OR, TX, WV.

HOW THIS PLAN WORKS

Plan A: Under this plan, you will receive a monthly benefit beginning on the 31st, 91st or 181st day of your covered Total Disability up to age 65 if Totally Disabled before age 64. For a Total Disability beginning on or after age 64, but before age 70, benefits will be payable for a maximum of 12 months.

Plan B: Under this plan, you will receive a monthly benefit beginning on the 31st, 91st or 181st day of your covered Total Disability up to age 65 for Injury or up to two years for Sickness. For a Total Disability beginning on or after age 64, but before age 70, benefits will be payable for a maximum of 12 months.

YOUR CHOICES

Plan A or Plan B: Determine the maximum amount of time to receive benefits.

Waiting Period: Your benefits will begin on the 31st, 91st, or 181st day of Total Disability.

Benefit Amount: Select from $500 to $4,000 per month (not to exceed 66 2/3% of your Basic Monthly Pay). Plus, this Plan pays in addition to any other disability benefits you might receive. Any recurrent Total Disabilities are also covered.

IMPORTANT PLAN FEATURES

Rehabilitative Employment Benefit: If you elect within 31 days of receiving monthly Total Disability benefits to participate in an approved vocational rehabilitation program, partial benefits will continue. The benefit will equal your chosen monthly benefit minus 80% of any gross income you receive, and it won't exceed 12 months.

Residual Disability Benefits: You may be eligible for partial benefits if (following a Total Disability that ended prior to age 65, and continued for 90 consecutive days) you should return to work but you suffer a continuous reduction of earnings as a direct result of the Sickness or Injury that caused the Total Disability. Your earnings must be less than 75% of your Basic Monthly Pay.

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[1]. 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 premiums you have paid will be promptly refunded, minus any claims paid.

IMPORTANT DEFINITIONS

Total Disability: The complete inability, due to Sickness, Injury or both, to perform the substantial and material duties of your own occupation during the Waiting Period and first 60 months of Total Disability. After that period of time, it is defined as the complete inability to perform the substantial and material duties of any gainful occupation for which you are reasonably suited by training, education or experience.

Basic Monthly Pay means your regular monthly rate of pay, not counting commissions, bonuses, overtime pay or any other fringe benefit or extra compensation, in effect on the last day of Active employment prior to becoming Totally Disabled. With respect to Insured Persons who are self-employed, Basic Monthly Pay means the net income after deduction of business expenses for the calendar year immediately preceding Total Disability.

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

Concurrent Disabilities
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 Total Disability resulted from only one cause.

Exclusions and Limitations:
This Policy does not cover: intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane; war or act of war, whether declared or not; 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.

Successive and Concurrent Disabilities Limitation
The insured member will receive their 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.

Termination of Coverage
You may keep this Plan until age 70, as long as the Master Policy remains in force, you remain a member of MNCPA or a full-time employee of a member, premiums are paid when due, you do not enter full-time active military duty, and remain Actively-at-Work except due to Total Disability covered by the Policy. Your spouse'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
If you become Totally Disabled for more than 6 consecutive months, you won't have to pay your premiums for as long as the Total Disability lasts, subject to the maximum period.

Semi Annual Individual Premiums
Rates Per $100 of Monthly Benefit Amount
Plan A

Attained Age	30 Day Waiting Period	90 Day Waiting Period	180 Day Waiting Period
Under 30	$7.80	$6.20	$3.10
30-39	10.00	8.40	4.00
40-49	12.60	10.60	5.70
50-59	16.40	14.80	9.80
60-69*	20.80	18.80	10.40

Semi Annual Individual Premiums
Rates Per $100 of Monthly Benefit Amount
Plan B

Attained Age	30 Day Waiting Period	90 Day Waiting Period	180 Day Waiting Period
Under 30	$4.00	$3.40	$1.20
30-39	5.40	4.60	1.60
40-49	7.40	6.40	2.60
50-59	11.20	10.20	5.30
60-69*	16.40	14.80	9.00

Rates and/or benefits will not be changed unless they are changed for all insureds in your classification.
Rates are based on the attained age of the Insured person and increase as you enter each new age category.
*Renewal premiums only.

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.

HOW TO APPLY

1. Complete, date and sign the enclosed Application. If your spouse is also applying, please complete the form and sign where indicated.
2. **Send no money now.** You will be billed when your Certificate is issued.
3. Mail your completed Application, for approval, in the enclosed return envelope.

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

Administered by:

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

QUESTIONS?
1-800-732-8350
www.mncpa-insurance.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

[1]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 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.

Disability Form Series includes SRP-1311, or state equivalent.

Policy Number AGP-5182 7/16 ed.
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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.

PA-9369

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