Dear,

Thank you for inquiring about the Minnesota Dental Association Group Insurance Program. Enclosed you’ll find the information you requested for the following plan: Group Disability Income Plan.

Before you take a look at the information I’ve enclosed, let me mention some of the important benefits you receive with all our insurance plans.

- These are "group" plans, negotiated especially for MDA Members. Rates, although not guaranteed, can only be changed on a group basis.
- Each plan is backed by a 30-day Free Look. After you receive your Certificate of Insurance, you have a full 30 days to review your new coverage. If you decide that it’s not exactly what you want and need, simply return it. Every dollar you’ve paid will be refunded, and your coverage will be invalidated, no questions asked — provided of course, you have not submitted any claims.

Please read the enclosed brochure for more information, including eligibility, renewability, costs, exclusions, limitations and terms of coverage on this plan.

Once you determine the type and amount of personal insurance protection you need, simply complete and return the application in the postage-paid envelope provided for approval. If you have questions along the way, just pick up the phone and call us. Our toll-free number is: 1-866-810-9384.

Whatever your personal situation, I hope you’ll take a few minutes today to candidly assess your family’s insurance needs and apply to bring your coverage up-to-date through this exclusive member program. Please return your application today!

Yours truly,

Terence B. Bernier
Managing Director
Marsh U.S. Consumer
a Service of Seabury & Smith, Inc.
#2177453

P.S. Each insurance plan is offered through a well respected, highly rated insurance company, and every plan carries a 30-day Free Look!

Marsh U.S. Consumer
a Service of Seabury & Smith, Inc.
P.O. BOX 14464 • Des Moines, IA 50306
1-866-810-9384 • mda@marshpm.com • www.mndentalsolutions.com

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AGP-5641
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**For Members of the Minnesota Dental Association**

**DISABILITY INSURANCE APPLICATION**

**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

Simsbury, Connecticut 06089

---

**The Hartford TO APPLY:**

1. Complete and sign the application
2. Send no money with your application. You will be billed upon approval.
3. Use the postage paid envelope provided to return to:
   MDA GROUP INSURANCE PROGRAM
   P.O. Box 14464
   Des Moines, IA 50306
   E-Mail: mda@marshpm.com

---

**MINNESOTA DENTAL ASSOCIATION**

---

**Section 1**

Association Name: Minnesota Dental Association  
Policy No.:   
Certificate No.: (Leave Blank)

---

**Section 2**

Name: (First, Middle Initial, Last)  
[ ] Male  
[ ] Female  
Height: _____ ft. _____ in.  
Weight: _____ lb.

Street:   
City:   
State:   
Zip Code:

Date of Birth (MM/DD/YYYY):   
Age Last Birthday:   
Place of Birth (State/Country):

Daytime Phone No.:  
[ ] Business Telephone:  
Email Address:  
Occupation:   
Annual Salary: $___________

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/Domestic Partner’s Name: (First, Middle Initial, Last), if applying

[ ] Male
[ ] Female

Height: _____ ft _____ in. Weight: _____ lb.

Street: 
City: 
State: 
Zip Code: 

Date of Birth (MM/DD/YYYY): 
Age Last Birthday: 
Place of Birth (State/Country): 

Spouse/Domestic Partner’s Occupation: 

Annual Salary: $__________

Daytime Phone No.: 
Business Telephone: 

Business Address: Street:

City: 
State: 
Zip Code: 

Beneficiary - Print full name & relationship to you

Name: ____________________________________________________________ Relationship: __________________________

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: [ ] 90 days [ ] 180 days

Spouse/Domestic Partner Coverage:

[ ] New Coverage: Monthly Benefit Amount: $__________________

[ ] Change in Coverage:

Increase my Monthly Benefit Amount to: $__________________

[ ] Change in Waiting Period:

Waiting Period: [ ] 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:

<table>
<thead>
<tr>
<th>Company</th>
<th>Monthly Benefit</th>
<th>Benefit Period</th>
<th>Waiting Period</th>
<th>To be replaced</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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/Domestic Partner: [ ] Yes [ ] No

Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Pre-Disability Earnings minus any Other Income Benefits? 

You: [ ] Yes [ ] No 

Spouse/Domestic Partner: [ ] Yes [ ] No

The Hartford® is Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company.

Form PA-9357 (HLA) (CA)

ID648CAE-AGP5541E

00000050-0000004-00000034
Section 6

PLEASE COMPLETE THE FOLLOWING:

<table>
<thead>
<tr>
<th>All questions are answered to the best of my knowledge and belief:</th>
<th>YES/NO</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In the past 10 years, has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Colitis, ulcer, kidney disease or disorder or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is anyone proposed for coverage now pregnant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, Name: ____________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When is the baby due? ______________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was your pre-pregnancy weight? __________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any medical complications?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 7

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

<table>
<thead>
<tr>
<th>Question Number and Condition</th>
<th>Name of Family Member</th>
<th>Dates</th>
<th>For any question answered &quot;yes&quot; please provide details, including dates, your physician's name, full address, phone number and fax number. (Required for processing)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Section 8

AUTHORIZATION

I hereby certify that I have read or have had read to me all statements and answers in this application, and in any other application or medical form required by Hartford Life and Accident Insurance Company, and that they are full, complete, and true to the best of my knowledge and belief. I understand that any material misrepresentations in this application could cause a claim to be denied under any insurance issued based on this application. I 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 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 pay the first premium.

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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 and Accident 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 and Accident 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 understand the Medical Information Bureau, Inc. will release records or information only to Hartford Life and Accident Insurance Company.

I authorize Hartford Life and Accident Insurance Company to give information about me/us 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.

I certify that I have received the Notice of Insurance Information Practices. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

PRE-EXISTING CONDITIONS LIMITATION: I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month 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, or until 1 year after my 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 certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation.

I further understand that any condition excluded or limited by the Policy or by a Health Waiver attached to my certificate will not be covered under this Policy at any time.

Notice: I understand that California law prohibits an HIV test from being required or used by Health Insurance Companies as a condition of obtaining health insurance coverage.

Section 9
I wish to pay my premiums: ☐ Automatic Monthly Check Withdrawal ☐ Semi-Annual Direct Bill
(If you select Automatic Check Withdrawal, please complete the Automatic Monthly Check Withdrawal Request.)

Section 10
Member’s signature (Sign name in full) _______________________________ Date ____________________
Required Required

Spouse/Domestic Partner’s signature (if applying) __________________________ Date ____________________
Required Required

Send this completed form to:

ADMINISTRATOR
MDA GROUP INSURANCE PROGRAM
P.O. Box 14464
Des Moines, IA 50306
1-866-810-9384
mda@marshpm.com

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Form PA-9357 (HLA) (CA) ID:648CAE-AGP5541E
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 _____________
THIS PAGE IS INTENTIONALLY LEFT BLANK.
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. **Remember to include your first premium and a blank voided check with your application.**

Bank Name: ________________________________________________________________

Bank Address: ______________________________________________________________

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

Don’t Let A Disabling Accident or Sickness Threaten Your Family’s Financial Security...

Help make sure your financial future is secure with Group Disability Income Insurance

Up to $7,500 in Monthly Benefits
Members of the Minnesota Dental Association and employees of Members and/or Spouse/Domestic Partner under age 60, who have been Actively-at-Work (at least 25 hours per week), reside in the U.S., may apply for disability income coverage. A Spouse can not be legally separated or divorced from the Member.

Choose the Amount of Benefit You Need
You may choose benefit amounts from a minimum of $200 up to $7,500 per month (your benefit amount cannot exceed 60% of your Basic Monthly Pay, minus any Other Income Benefits). Once Totally Disabled, benefits elected will begin on the first day following completion of your selected waiting period (90 or 180 days).

Benefit Period
For Members and/or Spouse/Domestic Partner:
Option I: For Total Disability beginning: before age 61: 5 years; age 61 or over, but under 62: 4 years; age 62 or over, but under 63: 3 years; age 63 or over, but under 70: 2 years.

Option II: For Total Disability beginning: before age 63: to age 65; age 63 or over, but under 70: 2 years

For Employees of Members and/or Spouse/Domestic Partner: Option I: 2 Years.

Recurrent Disability
In order to re-qualify for full benefit periods, each disability period must be separated by at least 6 consecutive months during which the insured is Actively-at-Work, or the later disability is caused by an unrelated cause.

Ability Plus Benefit
We will pay you the Ability Plus Benefit if: 1) Monthly Benefit is payable under this plan for being Disabled; and 2) during or after the Waiting Period, you become unable to perform two or more Activities of Daily Living (ADL’s) for which you can not be reasonably accommodated by adaptive equipment; and 3) inability to perform two or more ADL’s has lasted for at least 30 consecutive days; and 4) the Disability and such impairment or inability begins while you are covered under this benefit. The amount of the Ability Plus Benefit will be 10% of your Monthly Income Loss.

The Ability Plus Benefit will not:
1) be reduced by Other Income Benefits; or
2) increase or reduce other benefits under this plan; or
3) be subject to the Cost of Living Adjustment.
You are not restricted in any way as to your use of this Ability Plus Benefit.

Activities of Daily Living (ADL’s) mean the following functions performed with or without equipment or adaptive devices: 1) bathing yourself by being able to either: a)wash yourself in a tub or shower devices; or b)give yourself a sponge bath; or 2) dressing yourself by putting on and taking off needed garments; or 3) using the toilet by being able to get to and from, and on and off the toilet, and performing the associated hygienic tasks; or 4) transferring from bed to chair or wheelchair; or 5) bladder and bowel control by being able to either: a) voluntarily control bowel and bladder function; or b) maintain a reasonable level of personal hygiene, if you are not so able; 6) feeding yourself, once the food has been prepared and made available to you.

Ability Plus Termination
The Ability Plus Benefit will cease to be payable on the date:
1) your Monthly Benefit payments for being Disabled terminate for any reason; or
2) you are able to perform the two or more Activities of Daily Living you were previously unable to perform.

Rehabilitative Employment Benefit
If, while you are Totally Disabled, you accept Rehabilitative Employment, you will continue to receive a Monthly Benefit Amount.

The Monthly Benefit Amount will be equal to your Accident and Sickness Total Disability Monthly Benefit Amount, less 50% of any income received from the Rehabilitative Employment.

The sum of the Monthly Benefit Amount and total income received from a program of Rehabilitative Employment may not exceed 100% of your Basic Monthly Pay. If this sum exceeds the Basic Monthly Pay, the Monthly Benefit Amount paid will be reduced accordingly.
Coordination of Benefits
The benefits will be coordinated with any other benefits you are entitled to receive from: Worker’s Compensation or other similar legislation; occupational disease laws; state disability benefits or other governmental legislation; employer-endorsed disability plans; disability or early retirement benefits received under the employer’s pension plan; Social Security disability or Civil Service disability benefits. In no event will the monthly benefits paid under this plan plus the income from the above sources exceed 60% of your Basic Monthly Pay at the time you become Totally Disabled.

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 for 30 days. 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.

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 70. Your spouse/domestic partner’s coverage will remain in effect as long as your coverage is active, premiums are paid, and they meet the eligibility requirements.

EXCLUSIONS
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; the commission or attempted commission of a felony by you.

Pre-Existing Condition Limitation
During the first year of coverage, losses incurred for Pre-Existing Conditions are not covered. A 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.

Mental Nervous Disorder Limitation:
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.

Defined Terms
Injury means bodily injury which results directly and independently of all other causes from an accident.

Total Disability means disability which: during the Waiting Period and the first 24 months during which Total Disability Benefits are payable, wholly and continuously prevents you from performing the substantial and material duties of your own occupation; and after that, wholly and continuously prevents you from engaging in any and every occupation or employment for which you are reasonably suited by training, education or experience.

With respect to an Insured Person who is not self-employed, Basic Monthly Pay means an Insured Person’s 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 Disabled.

Waiver of Premium
If you become Totally Disabled, and the disability continues 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 Individual Premiums Per $100 Monthly Benefit
Select the monthly income you need, from $200 to $7,500. Premiums are based on your selected waiting period, age when entering the program, and change as each new age bracket is reached. The Insurance Company reserves the right to change rates.
Semi-Annual Individual Premiums Per $100 Monthly Benefit

<table>
<thead>
<tr>
<th>Age</th>
<th>90 Day Waiting Period</th>
<th>180 Day Waiting Period</th>
<th>90 Day Waiting Period</th>
<th>180 Day Waiting Period</th>
<th>90 Day Waiting Period</th>
<th>180 Day Waiting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$4.96</td>
<td>$3.34</td>
<td>$8.84</td>
<td>$6.68</td>
<td>$3.82</td>
<td>$2.49</td>
</tr>
<tr>
<td>30-34</td>
<td>5.36</td>
<td>3.83</td>
<td>8.81</td>
<td>6.93</td>
<td>4.63</td>
<td>3.18</td>
</tr>
<tr>
<td>35-39</td>
<td>5.38</td>
<td>4.02</td>
<td>9.23</td>
<td>7.48</td>
<td>5.16</td>
<td>3.76</td>
</tr>
<tr>
<td>40-44</td>
<td>6.14</td>
<td>4.70</td>
<td>11.62</td>
<td>9.60</td>
<td>5.93</td>
<td>4.55</td>
</tr>
<tr>
<td>45-49</td>
<td>8.21</td>
<td>6.29</td>
<td>16.94</td>
<td>13.99</td>
<td>7.02</td>
<td>5.57</td>
</tr>
<tr>
<td>50-54</td>
<td>12.13</td>
<td>9.29</td>
<td>25.75</td>
<td>21.33</td>
<td>8.64</td>
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<tr>
<td>55-59</td>
<td>24.71</td>
<td>19.82</td>
<td>42.04</td>
<td>34.68</td>
<td>12.58</td>
<td>11.11</td>
</tr>
<tr>
<td>60-64*</td>
<td>30.76</td>
<td>22.33</td>
<td>40.11</td>
<td>29.43</td>
<td>17.79</td>
<td>16.43</td>
</tr>
<tr>
<td>65-69*</td>
<td>30.76</td>
<td>22.33</td>
<td>40.11</td>
<td>29.43</td>
<td>17.79</td>
<td>16.43</td>
</tr>
</tbody>
</table>

Rates and/or benefits are subject to change on a class basis.

*Only those under 60 may apply.

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

All billing modes except annual will include a $2.00 billing fee. To avoid the fee, select EFT as a safe and secure payment option.

It’s Easy to Apply!

1. Complete, date and sign the enclosed Application. If your spouse/Domestic Partner 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 in the enclosed return envelope for approval.

Marsh U.S. Consumer, a Service of Seabury & Smith, Inc.
P.O. Box 14464
Des Moines, IA 50306

Administered by:

MARSH

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident 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 and Accident 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. This program may vary and may not be available to residents of all states.

P.O. BOX 14464
Des Moines, IA 50306-9468
Call: 1-866-810-9384
Web: www.madentsolutions.com

AR Ins. Lic. #245544
CA Ins. Lic. #0633005
d/b/a in CA Seabury & Smith Insurance Program Management

Underwritten by:

THE HARTFORD

Hartford Life and Accident Insurance Company
Simsbury, CT 06089
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

Policy Form # SRP-1311 A (HLA) (5541)

Brochure # SRH-3357-LV

IDI648P-AGP5541P

January 2011
Group Disability Income Insurance Protection Plan
Rate Calculation

1. Choose your waiting period.
   Decide whether you would like your benefit payments to begin after 90 days or 180 days of Total Disability.

2. Calculate your benefit.
   Given your current income and existing disability benefits, you can calculate the amount of group disability income insurance you’re eligible to purchase through the Group Disability Income Protection Plan. The actual benefit you receive at a time of claim may be different, depending upon your income, offsets for other income benefits, and reductions. Benefits will be affected by Social Security and Worker’s Compensation.

**BENEFIT CALCULATION TABLE:** This example is based on an annual income of $25,000

<table>
<thead>
<tr>
<th>Step Description</th>
<th>Example</th>
<th>Yours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Monthly income (before taxes)</td>
<td>$2,083</td>
<td></td>
</tr>
<tr>
<td>2. Multiply by .60 (your monthly benefit percentage)</td>
<td>$1,249</td>
<td></td>
</tr>
<tr>
<td>3. Offsets (add in any other monthly income benefits like</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Social Security or Worker’s Compensation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sub-total (subtract Line 3 from Line 2)</td>
<td>$1,249</td>
<td></td>
</tr>
<tr>
<td>5. Your total monthly benefit (round to the nearest $100)</td>
<td>$1,200</td>
<td></td>
</tr>
</tbody>
</table>

3. Calculate your premium.
   From the premium chart, determine the appropriate rate of monthly disability benefit based on **Elimination Period** and **Age**.

<table>
<thead>
<tr>
<th>Step Description</th>
<th>Example</th>
<th>Yours</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Enter Rate selected from brochure (for this example we used the Five Year Plan, 90 Day Elimination period, and Age 40-44).</td>
<td>$6.14</td>
<td></td>
</tr>
<tr>
<td>B. Divide Line 5 from BENEFIT CALCULATION by 100 (this will determine the number of Monthly Units you will receive).</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>C. Multiply the amount from line A by the amount from Line B to obtain monthly premium.</td>
<td>$8.16</td>
<td></td>
</tr>
<tr>
<td>D. If you select semi-annual Direct Bill as your payment option, multiply line C by 6.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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