

Application for Disability Income Insurance  
 New York State Business Group, Inc.  
 AGP-5666



Hartford Life Insurance Company  
 Simsbury, CT 06089

PERSONAL INFORMATION (ALL Applicants Complete this section):					
Applicant's Full Name <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.			Date of Birth	Place of Birth (City/State/Country)	
Street Address		Height Weight ___ft. ___in. ___lbs	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
City State ZIP		Occupation			
Membership/Eligibility No.:					
Spouse Name (if Applying)		Height Weight ___ft. ___in. ___lbs	Occupation	Date of Birth	Place of Birth (City/State/Country)

COVERAGE REQUESTED (ALL Applicants Complete this section):		
Monthly Benefit Amount Member ___\$ Spouse ___\$	Waiting Period Option <input type="checkbox"/> 60 days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days	Payment Period Option <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual
<input type="checkbox"/> New Coverage <input type="checkbox"/> Change in Coverage New Benefit Amount = \$_____	Plan Choice <input type="checkbox"/> 2-year <input type="checkbox"/> 5-year <input type="checkbox"/> To Age 65	

**ALL Applicants Read and Answer the following questions:**

1. Have you been actively engaged in the full-time duties of your occupation (minimum [30] hours/week) immediately before the date of this application?  
 You:  Yes  No Spouse:  Yes  No

2. Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company?  
 If yes give details  
 Name Company Monthly Benefit \$ Benefit period To Be replaced ?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 You:  Yes  No Spouse:  Yes  No

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

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

If Yes, amount used daily? Member \_\_\_\_\_ Spouse \_\_\_\_\_

**Use This Section When Applying for a monthly benefit of \$4,000 or less**

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 lung or respiratory disorder, kidney or genitourinary disorder, alcohol or drug dependency, mental or nervous disorder, bone, joint, back, muscle or connective tissue disorder, or chronic fatigue syndrome?  
 You:  Yes  No Spouse:  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)?  
 You:  Yes  No Spouse:  Yes  No

3. Have you been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity)?  
 You:  Yes  No Spouse:  Yes  No

**AUTHORIZATION:** 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.

By signing below, I acknowledge that I have read and agree to all terms on the reverse of this form.

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature required Date Spouse Signature required if applying Date

Policy Form # SRP-1311 AP (HL)(AGP-5666)

USE BACK OF FORM TO APPLY FOR MONTHLY BENEFIT AMOUNTS OF \$4001.00 AND ABOVE AND/OR "TO AGE 65" PLANS



**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.

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