Customer Service: 1-800-241-7753 Ext 8922
Customer Service Fax: 1-866-634-9370

Underwritten By
Hartford Life & Accident Insurance Company
Simsbury, Connecticut

APPLICATION FOR DISABILITY INCOME INSURANCE

Endorsed by The University System of New Hampshire

COMPLETE AND MAIL TO: USNH Human Resource Office • Dunlap Center • 25 Concord Road • Durham, NH 03824

Member Application for Insurance — ISI Insurance Trust Policy Number AGP-5315

Applicant's Name *(First, Middle, Last)*			Name of Organization University System of New Hampshire		
Address *(Street, City, State, Zip Code)*					Phone Number
Sex	Date of Birth	Place of Birth *(City, State)*	Height *(Ft. In.)*	Weight *(Lbs.)*	E-mail Address

INDICATE THE WEEKLY BENEFIT DESIRED *(in $100 increments):* $ _____

PAY PREMIUMS BY: ❑ Payroll Deduction

INDICATE BENEFIT PERIOD DESIRED: ❑ 26 weeks Accident and Sickness

INDICATE WAITING PERIOD DESIRED: ❑ 0 Days Accident 7 Day Illness

OTHER INSURANCE INFORMATION		**Yes**	**No**
1	Do you have any disability income insurance in force or pending with this or any other company?		
	COMPANY:_____ MONTHLY BENEFIT: _____ WAITING PERIOD: _____ BENEFIT PERIOD: _____ TO BE REPLACED: _____		
2	Is the monthly benefit amount applied for equal to or less than 70% or your basic monthly earned income less any other disability income insurance you may have in force?		
3	Have you been actively engaged in the full-time duties of your occupation during the 90 day period immediately before the date of this application?		
PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS ON THE REVERSE:		**Yes**	**No**
4	Have you ever been diagnosed or treated by a member of the medical profession for:		
4 a	A heart murmur, high blood pressure, stroke, or any disease or disorder or the heart, blood or circulatory system?		
4 b	Asthma, shortness or breath, tuberculosis or any disease or disorder of the lungs or respiratory system?		
4 c	Colitis, ulcer, kidney disease, or any disease or disorder of the digestive, urinary or reproductive system?		
4 d	Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?		
4 e	Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?		
4 f	Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?		
4 g	Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)*		
5	During the past 5 years have you consulted any physician, surgeon, psychologist psychiatrist or other medical or dental practitioner or anything other than a routine physical, eye examination or dental examination for any reason not previously noted on this application; or been confined or treated in any hospital, sanatorium or similar institution?		
6	Are you now pregnant? *If yes, when is the baby due:*_____ *Are there any medical complications?*_____		

**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 while 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.*

If you answered "Yes" to any of the questions on the front, please explain the details. Explain nature of illness, number of attacks, duration, severity, treatment, names and addresses of physicians, hospitals and date of full recovery. *(Attach sheet of paper if additional space is needed.)*

QUESTION #	NAME	DISORDER OR REASON	DATES TO/ FROM	DETAILS

AUTHORIZATION

I hereby certify that all statements and answers In this application, and In any other application or medical form required by the Company, 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 contest the validity of the coverage, within the contestable period If such misrepresentation materially affects the acceptance of the risk. I also understand that the Company may request whatever additional evidence of Insurability It needs. 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.

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 Hartford[1] 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. Hartford[1] 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[1]. I authorize the Hartford[1] 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. I certify that I have received the Notice of Insurance Information Practices.

I understand that any Injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment In the 6 month period prior to my effective date of coverage will not be covered until I have gone 6 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 or by a Health Waiver attached to my certificate. Applications to Increase my 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.

STATE NOTICE

Any person who includes any false or misleading information on an application 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 policy holder 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.

Signature of Member _____ Date _____

Signature of Agent _____ Date _____

[1]The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including the issuing company of Hartford Life and Accident Insurance Company.