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 Guild of Organists	Policy No. AGL-1544	Certificate No. (Leave Blank)	
Proposed Insured's Name (First, Middle Initial, Last)	❑ Male ❑ Female	Date of Birth:	Height: __ft. __in. Weight: ______lb.
Street City State Zip Code	Phone No. ( )	E-mail Address: __________________	

Proposed Insured's Occupation

Beneficiary — Print full name & relationship to you

Name ____ Relationship ______________________________________

The Proposed Insured will be the beneficiary for any Dependent Coverage desired.

Spouse's Name (First, Middle Initial, Last), if applying	❑ Male ❑ Female	Date of Birth:	Height: __ft. __in. Weight: ______lb.
Street City State Zip Code	Phone No. ( )	E-mail Address: __________________	

Beneficiary — Print full name & relationship to you

Name ____ Relationship ______________________________________

Amount Desired (minimum of $15,000 up to $210,000 maximum in $15,000 increments)

Please indicate if request is for: ❑ New Coverage

Member:	❑ $210,000	❑ $195,000	❑ $180,000	❑ $165,000	❑ $150,000	❑ $135,000	❑ $120,000
	❑ $105,000	❑ $ 90,000	❑ $ 75,000	❑ $ 60,000	❑ $ 45,000	❑ $ 30,000	❑ $ 15,000
Spouse:	❑ $210,000	❑ $195,000	❑ $180,000	❑ $165,000	❑ $150,000	❑ $135,000	❑ $120,000
	❑ $105,000	❑ $ 90,000	❑ $ 75,000	❑ $ 60,000	❑ $ 45,000	❑ $ 30,000	❑ $ 15,000

The Spouse 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's Current benefit amount: $_____________ Additional benefit requested: $_____________ Total benefit: $_____________

Child(ren) Coverage: ❑ Yes ❑ No

❑ I wish to add Accidental Death coverage to my Group Term Life plan.

Form SRP-1153 AP (D) (HL)

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If Dependent Coverage is desired, complete the following:

Full Name	Relationship	Birth Date	Height	Weight

	Member	Spouse
PLEASE COMPLETE THE FOLLOWING:	YES/NO	YES/NO
1. In the last 2 years, have you or your Spouse 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.

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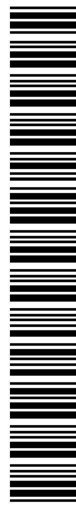

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

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'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: ❑ 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.

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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:
AGO 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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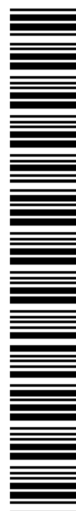

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AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

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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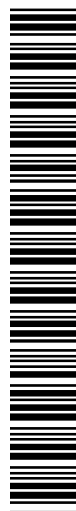

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Group Term Life Insurance Plan

For Members of the American Guild of Organists

- Up to $210,000[1] in life insurance coverage
- Double benefit option for accidental death

The Group Term Life Insurance Plan and how it works ...

Coverage amounts

You can apply for $15,000 to $210,000 in coverage (in $15,000 increments), subject to satisfactory evidence of insurability and approval of your completed application.

Double benefits option for accidental death

You can select to double your chosen benefit if you should die as a result of a covered accidental Injury. Double your coverage to a maximum of $420,000[1]. Death must occur as the direct and independent result of an Injury, within 90 days after the date of the accident that caused the Injury. $0.88 for each $15,000 unit will be added to your monthly premium if you select this option. **Be sure to check the appropriate box on the application for this benefit**.

Injury means bodily injury resulting directly and independently of all other causes from accident which occurs while you are covered under this Policy.

Who can apply?

You are eligible to apply as long as you are a member of your Association or the Spouse/certified Domestic Partner of a member. Both you and your Spouse/certified Domestic Partner must be under age 65, not confined for medical care or treatment in an institution or at home, not on full-time active duty in the armed forces of any country or international organization, and not insured under the Group Policy as a dependent. For certified Domestic Partner coverage, please contact the administrator for an affidavit. The Spouse can not be legally separated or divorced from the member.

Your unmarried, dependent children from ages six months to 23 years are eligible for $1,200 each. Children ages 14 days to six months are eligible for $120 each. Coverage increases automatically to $1,200 at 6 months of age.

This coverage is available only for residents of the United States excluding ID, MD, MT, NM, OR, SC, SD, VT, and WV.

Premiums waived if you become Totally Disabled

If you become Totally Disabled before age 60 by Sickness or Injury, and the disability continues for more than 6 consecutive months, your coverage will continue and you won't have to pay your premiums for as long as the disability lasts or until you attain age 80.

Total Disability means your disability which is caused by bodily Injury or diseases 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.

When coverage starts

Coverage becomes effective on the first day of the month following the date Hartford Life Insurance Company approves your application and your first premium is paid. If, on this date, you are not Actively-at-Work (at least 30 hours per week) you will not be so covered until the earlier of: the first day of the month on or next following the date you complete 90 consecutive days of full time Active Employment; or if not employed, the first day of the month on or next following the date you have been able, for 90 consecutive days, to carry on all the normal and customary activities of a person of like age and sex in good health.

Acceptance into this plan is subject to medical evidence of insurability as determined by Hartford Life Insurance Company. 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

Your coverage can continue up to age 80 as long as you remain a member of your Association, you continue to pay your premiums on time, you do not enter full-time active duty in the armed forces of any country or international organization and the Master Policy does not terminate. Your dependent's coverage will remain in effect as long as your coverage is active, premiums are paid, and they meet the eligibility requirements.

Exclusions

Benefits paid for death caused by suicide while sane or insane (in Missouri while sane) within the first two years of effective date of insurance are limited to a refund of the premiums paid for the insured's insurance. Benefits payable following the two years after an increase in coverage will be the amount of insurance in force prior to the increase plus premiums paid for the increase.

The Accidental Death Benefit does not cover death resulting from: suicide or attempted suicide or intentionally self-inflicted injury while sane or insane (in Missouri while sane), disease, bodily or mental infirmity, or medical or surgical treatment for these conditions; bacterial infections, except when caused by an accident or medical treatment of an accidental injury; operating, riding in, or descending from any kind of aircraft, except when riding solely as a passenger on a licensed, commercial non-military aircraft; declared or undeclared war, including resistance to armed aggression; committing or attempting to commit a felony, or resulting confinement; participation in a riot.

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Payment options

Automatic Monthly Check Withdrawal: Have your premiums deducted automatically from your checking account on a monthly basis.

Semi-Annual Direct Bill: Have your premiums billed to you directly on a semi-annual basis.

Double Benefit Option for Accidental Death: $0.88 per month per $15,000 unit/$5.25 for Semi-Annual Direct Bill.

If you elect to pay through Semi-Annual Direct Bill, find the appropriate monthly rate below and multiply by six.

Children's coverage: $0.38 monthly/$2.30 semi-annually covers all children for benefit amounts listed in the "Who can apply" section of the brochure.

*For renewal purposes only. Only those under age 65 may apply.

Semi Annual Premiums Per $15,000 Benefit Amount

Applicant's Age	Rates for amounts up to $100,000	Rates for amounts over $100,000
Under 30	$16.32	$14.16
30–34	17.64	15.36
35–39	22.68	19.68
40–44	33.36	29.04
45–49	51.60	44.88
50–54	80.16	70.08
55–59	124.56	108.36
60–64	181.20	157.56
65–69*	136.08	118.32
70–74*	94.92	82.56
75–79*	163.92	142.56

[1]At age 65, benefits reduce to 50% of the original amount and at age 70, benefits reduce to 25% of the original amount (on anniversary date coinciding with or following the date he/she enters the new age bracket). Coverage terminates at age 80. Rates will not be changed unless they are changed for all insureds in your classification. Rates and benefits depicted are subject to change not more frequently than once in a 12-month period.

Rates are based on the attained age of the Insured Person and increase as you enter each new age category. Rates and/or benefits may be changed on a class basis.

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 the enclosed application and be sure to indicate your desired coverage amount.
2. Remember to indicate your billing preference. If you select Automatic Monthly Check Withdrawal, you must include a check for your first monthly premium and a blank voided check. If you select Semi-Annual Direct Bill, just include a check with your application.

Mail to:
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?
1-800-503-9230
http://www.personal-plans.com/ago

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

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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.

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Policy Form #SRP-1153 A(HL)(1544)
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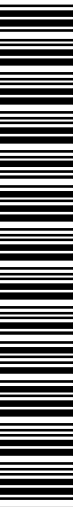

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NOTICE OF INSURANCE INFORMATION PRACTICES

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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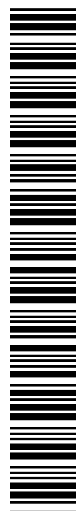

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