

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
ONE HARTFORD PLAZA
HARTFORD, CONNECTICUT 06155
(A STOCK INSURANCE COMPANY)



Group Senior Term Life Insurance Enrollment Form
Group Policyholder: Marine Corps Association (MCA)
Policy # AGL-1986

SECTION 1

MEMBER INFORMATION

Member's Name: _____ **Association Membership Number:** _____

Are you a Member of the Association? Yes No

Street: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Member's Social Security Number: _____ **Member's Date of Birth:** _____ **Gender:** Male Female

Email Address: _____ **Preferred Phone #:** _____

SECTION 2

Is Spouse's coverage desired? Yes No **Spouse's Full Name (If Enrolling)** _____

Spouse's Date of Birth: _____ **Gender:** Male Female

Spouse's Social Security Number: _____

SECTION 3

COVERAGE INFORMATION

Life Insurance

The amount requested subject to a minimum of \$5,000 and a maximum of \$25,000 in \$5,000 increments.

Member:

\$5,000 and a maximum of \$25,000 in \$5,000 increments. _____

I Accept – Sign/Date/Mail

Spouse (if enrolling):

\$5,000 and a maximum of \$25,000 in \$5,000 increments. _____

I Accept - Sign/Date/Mail

By enrolling for this insurance, do you intend to replace, discontinue or change an existing policy of Life Insurance?

If not, simply check "No".

Member: Yes No

Spouse: Yes No (if enrolling)

SECTION 4

CONFIRMATION

I acknowledge that I have been given the opportunity to enroll in the **MCA Group Senior Term Life Insurance Plan**. I certify that I am age 50 to 74, an Association Member and that the above information is true and complete to the best of my knowledge. If I enroll today and want to upgrade coverage at a later date, I may be required to submit Evidence of Insurability.

I understand and agree that insurance will go into effect upon receipt of my first premium payment and this form and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to Association can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy

I understand that during the first two years of coverage, the benefit payable for death due to sickness will be the premiums paid plus annual interest. After two years of coverage, the benefit payable for death due to sickness will be the full benefit amount. At any time, the benefit payable for death due to accident will be the full amount. If I have Life Insurance with The Hartford, I understand and agree that my Life Insurance benefit(s) reduce at a specified age(s) stated in the policy.

Do you wish to receive your Certificate of Insurance by secure email? Yes No

If the "Yes" checkbox is selected, please provide your email address: _____

Member's Signature: _____ **Date:** _____

Spouse's Signature (if enrolling): _____ **Date:** _____

SECTION 5

FRAUD NOTICE(S)

For Residents of Florida: Any person who 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 is guilty of a felony of the third degree.

For Residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For Residents of Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For Residents of New York (Not applicable to Life Insurance): 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 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement may have violated the state law.

**MAIL YOUR COMPLETED ENROLLMENT FORM TO:
1200 E. GLEN AVE, PEORIA HEIGHTS, IL 61616-5348
QUESTIONS? CALL 1 (800) 845-4685
EMAIL CUSTOMERSERVICE@INSUREMCA.COM**