HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

MCA GROUP TERM LIFE INSURANCE PLAN APPLICATION

1. COMPLETE AND SIGN THE APPLICATION.
2. SEND NO MONEY WITH YOUR APPLICATION. YOU WILL BE BILLED UPON APPROVAL.
3. PLEASE RETURN TO:
MCA GROUP INSURANCE PROGRAM
1200 E. GLEN AVE. PEORIA HEIGHTS, IL 61616-5348

1. PLEASE COMPLETE THE FOLLOWING INFORMATION:

Last Name | First Name | Middle Initial

Address | City | State | Zipcode

Height | Weight | Date of Birth (MM/DD/YY) | Place Of Birth (State/Country)

Member Social Security Number | Daytime Phone Number

Sex: ❍ Male ❍ Female | Email Address

Beneficiary – Print Full Name | Relationship To You

2. PLEASE COMPLETE FAMILY INFORMATION (IF APPLYING)

Spouse Name (Last, First, Middle Initial)

Sex: ❍ Male ❍ Female | Date of Birth (MM/DD/YY) | Height | Weight

Place of Birth (State/County)

Child Name: | Date of Birth (MM/DD/YY) | **Sex: ❍ M ❍ F**

Child Name: | Date of Birth (MM/DD/YY) | **Sex: ❍ M ❍ F**

Child Name: | Date of Birth (MM/DD/YY) | **Sex: ❍ M ❍ F**

3. SELECT THE AMOUNT OF COVERAGE DESIRED ($25,000 MINIMUM UP TO $250,000 MAXIMUM IN $25,000 INCREMENTS)

Write-in the desired coverage ($25,000 minimum to $250,000 maximum, in $25,000 increments).

Member Amount Desired $ | Spouse Amount Desired $

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: ❍ **Y** ❍ **N** **Spouse:** ❍ **Y** ❍ **N**

4. PLEASE COMPLETE THE FOLLOWING QUESTIONS:

	MEMBER	SPOUSE
1. During the past 5 years, has anyone proposed for coverage been diagnosed with or been treated for any of the following: heart condition, diabetes, kidney or liver disorder, lung or respiratory disease, neurological impairment, blood or circulatory disorder (including high blood pressure), alcohol or drug abuse, cancer, or enlarge lymph glands?	❍ Y ❍ N	❍ Y ❍ N
2. Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)* or any other immune deficiency disorder (see reverse for complete definition)?	❍ Y ❍ N	❍ Y ❍ N
3. Has anyone proposed for coverage been confined in a hospital, nursing home, sanitarium or similar institution due to illness in the past 6 months (excluding maternity)?	❍ Y ❍ N	❍ Y ❍ N

5. PLEASE COMPLETE THE FOLLOWING:

Please review your answers 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/we understand that coverage will become effective only after approval by the Company and receipt of the first payment of premium. By signing this application, I/we acknowledge that the Application is true and accurate for each person to be insured.

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

Member's Signature X | **Date** (MM/DD/YY)

Spouse's Signature (If enrolling) **X** | **Date** (MM/DD/YY)

6. CERTIFICATION AND AUTHORIZATION

I hereby certify that I have read all statements and answers in this application and that they are full, complete and true to the best of my knowledge and belief. I understand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the coverage, within the contestable period if such misrepresentation materially affects acceptance of the risk. I understand that coverage will not become effective until The Hartford[1] grants its underwriting approval. I agree that subject to the deferred effective date provision that no insurance coverage shall become effective unless: a) The Hartford grants its underwriting approval; and b) at the time of payment of the first premium, I am living, and my insurability remains the same as that described in the application. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium. I certify that I have received the Notice of Insurance Information Practices.

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 The Hartford 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. The Hartford 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. I authorize The Hartford 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.

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

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 white blood cell production and maturation, and the immunedeficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythematosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

7. 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.

SEND NO MONEY WITH YOUR APPLICATION. YOU WILL BE BILLED UPON APPROVAL.

QUESTIONS? CALL NOW: (800) 845-4685

PLEASE COMPLETE FORM AND RETURN TO:

MCA GROUP INSURANCE PROGRAM

1200 E. GLEN AVE.

PEORIA HEIGHTS, IL 61616-5384

Life Form Series includes GBD-1000, GBD-1100, or state equivalent.