Federal Employee Member Application for Disability Income Insurance

IT'S EASY TO APPLY. SEND NO MONEY NOW.

1. How did you hear about this plan? ______________________________

2. E-mail address you prefer to have Wright correspondence sent to ______________________________

3. Employing Agency ______________________________

4. Complete the sections below for your desired coverage.

5. Sign and date the application where indicated on the reverse, then return to:
   Wright USA, 706 Philadelphia Pike, Suite 1, Wilmington, DE 19809

Hartford Life & Accident Insurance Company
Simsbury, Connecticut 06089

Administered by

GROUP DISABILITY INCOME INSURANCE APPLICATION

Hartford Life and Accident Insurance Company, Simsbury, Connecticut 06089

Please Print. Use Dark Ink. Do Not Erase. Initial All Changes. | For Office Use: h w

Policyholder: Wright USA-CSRS/FERS	Policy No. AGP-5389, AGP-5391	Certificate No.: (Leave Blank)	
Name: (First, Middle Initial, Last)	☐ Male ☐ Female	Height: _____ft. _____in	Weight: _______lb.
Street: / City:	State:	Zip Code:	
Date of Birth (MM/DD/YYYY):	Place of Birth (State/Country):		
Daytime Phone No.: ( ) / Business Telephone: ( )	Email Address:		
Occupation:	Basic Monthly Pay: $		
Business Address: Street:			
City:	State:	Zip Code:	

Beneficiary — Print full name & relationship to you. Name: Relationship:

COVERAGE REQUESTED: ☐ New overage: Monthly Benefit Amount: $____________________
☐ Change in Coverage: Increase my Monthly Benefit Amount to: $____________________

Do you have any Disability Income Insurance in force or pending in this or any other company? ☐ Yes ☐ No If yes, give details:

Company	Monthly Benefit	Benefit Period	Waiting Period	To be replaced? Yes	No

Have you been actively engaged in the full-time duties of your occupation (at least 17.5 hours per week) immediately before the date of this application?
☐ Yes ☐ No

Is the Monthly Benefit Amount herein applied for equal to or less than 65% of your Basic Monthly Pay minus any Other Income Benefits? ☐ Yes ☐ No

PLEASE COMPLETE THE FOLLOWING: All questions are answered to the best of my knowledge and belief:	YES	NO
1. In the past 10 years, have you 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 disorder, or liver disease or disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system?		
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, excluding HIV test?		
2. 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 been confined or treated in any hospital, sanatorium or similar institution?		
3. Are you now pregnant? When is the baby due? ____________ What was your pre-pregnancy weight? ____________ Are there any medical complications?____________		

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company.

Form PA-9357 (HLA) (CA)

If you answered “Yes” to any of the above medical questions, please explain the details below.

Question Number and Condition	Dates	For any question answered “yes” please provide details, including dates, your physician’s name, full address, phone number and fax number. (Required for processing)

(Attach sheet of paper if additional space is needed.)

AUTHORIZATION

I hereby certify that I have read or have had read to me all statements and answers in this application, and in any other application or medical form required by Hartford Life and Accident Insurance 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 understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. 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 pay the 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 and Accident Insurance Company 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.

Hartford Life and Accident Insurance Company 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 Hartford Life and Accident Insurance Company.

I authorize Hartford Life and Accident Insurance Company 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 agree that this document and all of its contents shall form a part of my enrollment request for group benefits.

PRE-EXISTING CONDITIONS LIMITATION: I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until one (1) year after my effective date of coverage, whichever comes first, 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 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.

Notice: I understand that California law prohibits an HIV test from being required or used by Health Insurance Companies as a condition of obtaining health insurance coverage.

Payment Period Option: Electronic Funds Transfer (EFT): ☐ Monthly ☐ Quarterly ☐ Annually

OR ☐ Direct Bill Quarterly

X Member’s signature (Sign name in full) ______________________ **Date** ____________

Required **Required**

Questions? Visit us at www.WrightUSA.com • Or call us at 1-800-424-9801