



Exclusively for ISMS and CMS Members... Application for Group Term Life Insurance

PBT Insurance Office • 300 South Wacker Dr., Suite 700 • Chicago, IL 60606 • Ph: 1-800-621-0748 • Fax: 1-312-922-2849



Hartford Life Insurance Company • Simsbury, Connecticut
Physicians' Benefits Trust • Policy Number AGL-1398

Applicant's Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Date of Birth: ____/____/____ Place of Birth: (Town, State) _____

Height ____ ft. ____ in. Weight _____ lb.

Amount Desired: \$ _____ Please indicate: New Coverage Change in Coverage

Dependent Child Coverage: Yes No

If Yes, full name: _____ Relationship: _____

Birthdate: ____/____/____ Height ____ ft. ____ in.

Beneficiary—Print full name and relationship to you

Name: _____ Relationship: _____

The proposed insured will be the beneficiary for any Dependent Coverage desired.

PLEASE BILL ME (Send No Money Now) Quarterly Semi Annual Annual

Please check "Yes" or "No": If accepted for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? Yes No

To be eligible for coverage, you must have been actively engaged in the full-time duties of your occupation, or if not employed, been able to perform the normal activities of a person of like age and sex during the 90 day period immediately before the date of this application.

At any time during the last 12 months, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff? Yes No

1. Have you ever had or been treated for a heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system, asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system, colitis, ulcer, kidney disease or disorder of the digestive, urinary or reproductive system, alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disorder of the brain or nervous system including mental or emotional disorders, cancer, tumor, diabetes, blood or sugar in the urine, or any disease or disorder of the glands, arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders? Yes No

2. Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)*? Yes No

* 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 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.

Spouse Application for Term Life Insurance

Applicant's Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Date of Birth: ____/____/____ Place of Birth: (Town, State) _____

Height ____ ft. ____ in. Weight _____ lb.

Amount Desired: \$ _____ Please indicate: New Coverage Change in Coverage

Dependent Child Coverage: Yes No

If Yes, full name: _____ Relationship: _____

Birthdate: ____/____/____ Height ____ ft. ____ in.

Beneficiary—Print full name and relationship to you

Name: _____ Relationship: _____

The proposed insured will be the beneficiary for any Dependent Coverage desired.

PLEASE BILL ME (Send No Money Now) Quarterly Semi Annual Annual

Please check "Yes" or "No": If accepted for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? Yes No

To be eligible for coverage, you must have been actively engaged in the full-time duties of your occupation, or if not employed, been able to perform the normal activities of a person of like age and sex during the 90 day period immediately before the date of this application.

At any time during the last 12 months, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff? Yes No

1. Have you ever had or been treated for a heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system, asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system, colitis, ulcer, kidney disease or disorder of the digestive, urinary or reproductive system, alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disorder of the brain or nervous system including mental or emotional disorders, cancer, tumor, diabetes, blood or sugar in the urine, or any disease or disorder of the glands, arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders? Yes No

2. Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)*? Yes No

* 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 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.

During the past 5 years, have you 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? Yes No

If you answered "Yes" to any of the previous questions, please explain the details below.

Question No.	Dates To/ From	Give details of nature of illness, duration, severity, treatment, names and address of physicians, hospitals, and date of full recovery.

AUTHORIZATION

I hereby certify that all statements and answers in this application, are full, complete, and true to the best of my knowledge and belief I also 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 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 Life 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 or employment status. Hartford Life 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 the Hartford Life Insurance Company.

I authorize the Hartford Life Insurance Company to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., and 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.

Signature of Spouse: _____ **Date:** ____/____/____

(if applying for coverage)

During the past 5 years, have you 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? Yes No

If you answered "Yes" to any of the previous questions, please explain the details below.

Question No.	Dates To/ From	Give details of nature of illness, duration, severity, treatment, names and address of physicians, hospitals, and date of full recovery.

AUTHORIZATION

I hereby certify that all statements and answers in this application, are full, complete, and true to the best of my knowledge and belief I also 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 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 Life 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 or employment status. Hartford Life 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 the Hartford Life Insurance Company.

I authorize the Hartford Life Insurance Company to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., and 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.

Signature of Applicant: _____ **Date:** ____/____/____

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.