

Short-Term Disability Income Insurance Plan

for Real Estate Professionals

Hartford Life and Accident
Insurance Company
Simsbury, CT 06089

AGP-5322

Underwritten by:

Marketed and Administered by:



P E A R L[®]
INSURANCE

Name: _____ Male Female
First Middle Last

Home Address: _____
Street City State Zip

Business Address: _____
Street City State Zip

Home Phone: (____) _____ Business Phone: (____) _____ Email: _____

Date of Birth: _____ Mo./Day/Yr. Place of Birth: _____ City, State Height: _____ Ft. _____ In. Weight: _____ Lbs.

Occupation: _____ Duties: _____

Monthly Benefit Amount

(\$100 to \$4,000 in units of \$100): _____

(Note: The Monthly Benefit Amount you are now applying for must be 60% or less than your Basic Monthly Pay minus any Other Income Benefits)

How much coverage should I choose?

You may choose a monthly benefit amount from \$100 to \$4,000 in \$100 increments. However, many insurance experts recommend the monthly benefit guidelines listed below. This is not intended to serve as financial advice. Please consult your personal financial advisor as individual needs may vary.

If your Annual Income is:	Your Monthly Disability Benefit should be:
\$30,000	\$1,500
\$35,000	\$1,700
\$40,000	\$2,000
\$45,000	\$2,200
\$50,000	\$2,500
\$55,000	\$2,700
\$60,000	\$3,000
\$70,000	\$3,500
\$80,000	\$4,000

Health Questions

Am I eligible for coverage?

To be eligible for coverage, you must be under age 65 and have been actively engaged in the full-time duties of your occupation for the last 90-day period immediately before the date of this application. (Some restrictions may apply.)

Please answer the following:

1. During the last five years, have you been diagnosed or treated for cancer, tumor, high blood pressure, nervous system disorder, diabetes, any heart, blood, or circulatory disorder, autoimmune disorder, gastrointestinal disorder, any lung or respiratory disorder, kidney or genitourinary disorder, alcohol or drug dependency, mental or nervous disorder, bone, joint, back, muscle, or connective tissue disorder, or chronic fatigue syndrome? Yes No
2. Have you been diagnosed or been treated for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)* or any other immune deficiency disorder? Yes No
3. Have you been confined in a hospital, nursing home, sanitarium, or similar institution in the last six months (excluding maternity)? Yes No

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

(Continued on following page. Please sign and date.)

I further understand that any condition that is: excluded; or limited by the policy will not be covered under this policy at any time. 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, provided that the condition is not specifically excluded or limited by the policy.

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

Signature required to activate coverage

Date

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 Hartford¹ 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 companies Hartford Life Insurance Company and 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 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.

Applicant's Signature (Required)

Date (Required)

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.

Questions?

Call our professional representatives at **1-866-809-5175**
or visit www.pearlinsurance.com.

Please return your completed application to:



Pearl Insurance
1200 East Glen Avenue
Peoria Heights, IL 61616-5348
1-866-809-5175 or (309) 688-9000

FORM PA-9199 (5322) (HLA) (SI-DI3)
110162-RII-STD1-Gen
Printed in U.S.A.

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