

Application for  
**Long-Term Disability Income Insurance Plan**  
 Hartford Life Insurance Company  
 Simsbury, CT 06089

AGP-5206

**Get the Right Coverage  
 for Your Needs**

As you complete your application, refer to our helpful tips to choose the best coverage for you.

Underwritten by:



Marketed and Administered by:



Name: \_\_\_\_\_  Male  Female  
First Middle Last

Home Address: \_\_\_\_\_  
Street City State Zip

Business Address: \_\_\_\_\_  
Street City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

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

Occupation: \_\_\_\_\_ Duties: \_\_\_\_\_

Signature: \_\_\_\_\_

1. **Waiting Period** (check only one):  60 Days  90 Days  180 Days  365 Days

2. **Monthly Benefit Amount**  
 (\$100 to \$5,000 in units of \$100): \_\_\_\_\_

3. Is the Monthly Benefit Amount you are now applying for 60% or less than your Basic Monthly Pay minus any Other Income Benefits?  Yes  No

4. Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation during the six-month period immediately before the date of this application?  Yes  No

5. During the last calendar year, did your 1099 statement reflect at least \$30,000 of real estate transactions?  Yes  No

6. What is your average monthly salary (gross)? \_\_\_\_\_

7. Do you have any Disability Income Insurance in force or pending in this or any other company?  Yes  No  
 If "Yes" to question number 7, please give details below.

Name of Insurance Company(ies)	Monthly Benefit	Benefit Period	Waiting Period	To be replaced by this coverage?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

8. During the past 12 months, has anyone proposed for coverage smoked cigarettes, cigars, or used a pipe, chewing tobacco, nicotine chewing gum, or snuff?  Yes  No

**Please answer the following and give details for all "Yes" answers:**

1. Has anyone proposed for coverage ever 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Asthma, shortness of breath, tuberculosis, or any disease or disorder of the lungs or respiratory system?		<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Colitis, ulcer, liver, kidney disease, or any disease or disorder of the digestive, urinary or reproductive system?		<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness, or any disease or disorder of the brain or nervous system, including mental or emotional disorders?		<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?		<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?		<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)*, or any other immune deficiency disorder?		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. During the past five 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is anyone proposed for coverage now pregnant?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", give name: _____		
When is the baby due? _____		
Are there any medical complications?		<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered "Yes" to any of the above questions, please explain the details below. Attach a separate sheet if needed.**

Question Number	Name of Person	Date of Treatment		Disorder or Reason	Explain nature of illness, number of attacks, duration, treatment, and date of full recovery	Name and address of each physician practitioner, and medical facility
		From	To			

**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 the 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, as determined by a court of competent jurisdiction. 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.

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.

The Hartford<sup>1</sup> 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 aright to receive a copy of this form upon request.

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.

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 or 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.

**Questions?**

Call our professional representatives at **1-866-809-5175** or visit [www.pearlinsurance.com](http://www.pearlinsurance.com) today.

**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 SRP-1311 AP (A) (HL) (5206)  
100150-Rit-DI-Gen  
Printed in U.S.A

<sup>1</sup>The Hartford<sup>®</sup> is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life Insurance Company.