

Term Life Insurance Application

Hartford Life Insurance Company

Simsbury, CT 06089

Underwritten by:



Marketed and Administered by:



AGL-1537

Personal Information

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

Your Coverage

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

Beneficiary: _____ Relationship to you: _____

Dependent Life: Spouse \$ _____ Child(ren): Yes No

If you wish to include your spouse and/or eligible dependent children, complete this section.

Name (First, Middle, Last)	Sex	Date of Birth	Height	Weight

By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? Yes No

The following questions are to be answered for each person applying for coverage. Any misstatements may affect your coverage. Give full details to all "Yes" answers in the space provided.

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

To be eligible for coverage, you must have been actively engaged in the full-time duties of your occupation or if not employed, 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?
 Primary Insured: Yes No Spouse: Yes No

In the last two years, have you or your Spouse been unable to perform the full-time duties of your occupation for 10 consecutive days, or if not employed, been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90 day period immediately preceding the date of this application for 10 consecutive days?
 Primary Insured: Yes No Spouse: Yes No

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?
 Primary Insured: Yes No Spouse: Yes No

b) Asthma, shortness of breath, tuberculosis, or any disease or disorder of the lungs or respiratory system?
 Primary Insured: Yes No Spouse: Yes No

c) Colitis, ulcer, kidney disease, or any disease or disorder of the digestive, urinary, or reproductive systems?
 Primary Insured: Yes No Spouse: Yes 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?
 Primary Insured: Yes No Spouse: Yes No

e) Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?
 Primary Insured: Yes No Spouse: Yes No

f) Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?
 Primary Insured: Yes No Spouse: Yes No

g) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)* or any other immune deficiency disorder?
 Primary Insured: Yes No Spouse: Yes No

h) 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 have you been confined or treated in any hospital, sanatorium, or similar institution?
 Primary Insured: Yes No Spouse: Yes No

Complete the following for each "Yes" answer to Questions 1-5.

Question Number	Name of Person	Treatment Dates From	To	Give details of nature of illness, duration, severity, treatment, names and addresses of physicians, hospitals, and date of recovery.

If additional space is needed, please use a separate sheet. Sign, date, and return it with this form.

AUTHORIZATION

I hereby certify that I have read 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 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 paid my 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 Insurance Company or its legal representative information about my or my dependent's 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 above information to decide if and to what extent I or my dependents are 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 or my dependents to any other insurance company to whom I or my dependents may apply for Life and Health Insurance, the Medical Information Bureau, Inc., 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 my dependent's 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.

Applicant's Signature (Required) _____

Date (Required) _____

Spouse's Signature (Required if applying) _____

Date (Required if applying) _____

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: Yes No

Spouse: Yes No

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 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

*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.