



Long Term Disability Insurance Application

for members of the National Society of Professional Engineers

AGP-1311

PART A Personal Info

Please complete this form and return to:
NSPE Sponsored Plans, Pearl Insurance, 1200 East Glen Avenue, Peoria Heights, IL 61616-5348
Questions: Please call 800-438-2366 or 309-688-9000

PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE

Male
 Female

LAST NAME _____ FIRST NAME _____ MIDDLE _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 Date of Birth ___/___/___ Place of Birth _____ Height ___ ft. ___ in. Weight ___ lbs.
City/State
 Home Phone (_____) _____ Work Phone (_____) _____
 Fax (_____) _____ E-mail _____
For internal use only. E-mail address will never be sold or shared.
 Occupation: _____ Business Telephone: () _____ - _____ Duties: _____
 Monthly Earnings/Basic Monthly Pay: _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF SPOUSE COVERAGE IS DESIRED, PLEASE COMPLETE THE FOLLOWING:

Male
 Female

Spouse's LAST NAME _____ FIRST NAME _____ MIDDLE _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 Daytime Phone (_____) _____ Work Phone (_____) _____
 Date of Birth ___/___/___ Place of Birth _____ Height ___ ft. ___ in. Weight ___ lbs.
City/State
 Occupation: _____ Business Telephone: () _____ - _____ Duties: _____
 Monthly Earnings/Basic Monthly Pay: _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 30 hours per week) immediately before the date of this application? You: Yes No Spouse: Yes No

Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company? Yes No If yes, give details:

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

COVERAGE REQUESTED: New Coverage Change in Coverage
 Monthly Benefit Amount: _____ Payment Period Option: _____ Waiting Period Option: _____

Beneficiary (Print Full Name & Relationship): _____

Is the Monthly Benefit Amount herein applied for equal to or less than [60%] of your Basic Monthly Pay minus any Other Income Benefits? You: Yes No Spouse: Yes No

PART B Your Coverage

At any time during the past 12 months to the present, has anyone proposed for coverage smoked cigarettes, cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff?

You: Yes No Spouse: Yes No

If Yes, amount used daily? Member _____ Spouse _____

PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS BELOW: YES NO

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? YES NO
 - B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system? YES NO
 - C. Colitis, ulcer, liver, kidney disease, or any disease or disorder of the digestive, urinary or reproductive system? 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? YES NO
 - E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands? YES NO
 - F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders? YES NO
 - G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)* or any other immune deficiency disorder? YES NO

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? YES NO

3. Is anyone proposed for coverage now pregnant? YES NO
 If yes, Name: _____ When is the baby due? _____
 Are there any medical complications? _____

If you answered "Yes" to any of the above medical questions, please explain the details below. For any question answered "yes" please provide your physician's name, full address and phone number (required for processing). If additional space is needed, use a separate sheet. Sign, date, and return it with this form.

Ques. No.	Name of Person	Treatment Dates		Give details of nature of illness, number of attacks, duration, severity, treatment, names and addresses of physicians, hospitals, and date of full recovery.
		From	To	

*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.

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

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. 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 NSPE Plan Administrator 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.

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., 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 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 two (2) years 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.

Signature of Applicant _____ Date _____
(If proposed for insurance) Signature of Spouse _____ Date _____

I wish to pay my premiums: Quarterly Semi-annually Annually

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.

Underwritten by:
Hartford Life Insurance Company



NSPE Plan Administrator
1200 East Glen Avenue
Peoria Heights, IL 61616-9868
800.438.2366