Hartford Life and Accident
Insurance Company
Simsbury, CT 06089

National Society of Professional Engineers®

Term Life Insurance Application

for members of the National Society of Professional Engineers

AGP-1528

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

PART A Personal Info

LAST NAME ______ FIRST NAME ______ MIDDLE ______ ☐ Male ☐ Female

ADDRESS ______ CITY ______ STATE ______ ZIP ______

Date of Birth ___ /___ /___ Place of Birth ______________________ (City/State) Height ___ ft. ___ in. Weight ___ lbs.

Home Phone (________) ______________________ Work Phone (________) ______________________

Fax (________) ______________________ E-mail ______________________
For internal use only. E-mail address will never be sold or shared.

PART B Your Coverage

Amount Desired $____________________* Please Indicate ☐ New Coverage ☐ Change in Coverage

Your Beneficiary ______________________ Relationship ______________________

DEPENDENT LIFE: Spouse $____________________ Child(ren) ☐ Yes ☐ No

OPTIONAL ACCIDENTAL DEATH BENEFIT: ☐ Yes ☐ No

*The amount of insurance applicable to each Covered Person will be reduced by 50% at age 65 with an appropriate reduction in premium.

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

	Name if proposed for insurance	Date of Birth MO./ DAY / YR.	Height	Weight LBS	Sex
Spouse*	______________________	___ /___ /___	___ ft. ___ in.	______lbs.	☐ M ☐ F
Child*	______________________	___ /___ /___	___ ft. ___ in.	______lbs.	☐ M ☐ F
Child*	______________________	___ /___ /___	___ ft. ___ in.	______lbs.	☐ M ☐ F
Child*	______________________	___ /___ /___	___ ft. ___ in.	______lbs.	☐ M ☐ F

*See Plan information for definition of eligible dependents. If more than three children are proposed for insurance, attach a separate sheet. Please **sign and date** the additional sheet.

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

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? MEMBER ☐ Yes ☐ No SPOUSE ☐ Yes ☐ No

(Please read all items carefully, then sign and return last page.)

PART C Your Health

PLEASE REVIEW YOUR ANSWERS TO THESE QUESTIONS TO BE SURE THAT YOU HAVE ANSWERED THEM FULLY AND TRUTHFULLY. A MISREPRESENTATION ON THESE QUESTIONS COULD VOID YOUR COVERAGE. IF APPLYING FOR $100,000 OR LESS IN COVERAGE, ANSWERING "YES" TO ANY OF THESE QUESTIONS IN PART 1 DISQUALIFIES YOU FROM ACCEPTANCE FOR COVERAGE AT THIS TIME.

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

In the last 2 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? ☐ Yes ☐ No

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PART I

In the past 10 years 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, tuburculosis, or any disease or disorder of the lungs or respiratory system?
☐ Yes ☐ No

C. Colitis, ulcer, kidney disease, or any disease or disorder of the digestive, urinary, or reproductive systems?
☐ 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), AIDS Related Complex (ARC)*, or any other immune deficiency disorder?
☐ Yes ☐ No

PART II

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 have you been confined or treated in any hospital, sanatarium or similar institution?
☐ Yes ☐ No

If you answered "Yes" to any of the above questions, please explain the details below.
If additional space is needed, use a separate sheet. Sign, date, and return it with this form.

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

*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 or 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.

PART D Your Signature

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

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 and Accident 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 and Accident 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 and Accident Insurance Company. I authorize the Hartford Life and Accident 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.

____

Signature of Member — Date

____

Signature of Spouse — 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 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 there to, 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 and Accident Insurance Company

Administered by:
PEARL INSURANCE

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