

Business Owners Expense Protection Insurance Application

for members of the National Society of Professional Engineers

Hartford Life Life and Accident Insurance Company, Simsbury, CT 06089



National Society of Professional Engineers®

Male Female

LAST NAME _____ FIRST NAME _____ MIDDLE _____ () _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ HOME PHONE _____

DATE OF BIRTH _____ AGE _____ PLACE OF BIRTH (CITY/STATE) _____ HEIGHT (FT. IN.) _____ WEIGHT (LBS.) _____

OCCUPATION _____ DUTIES _____ EMAIL _____ () _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____ BUSINESS PHONE _____

Have you been actively engaged in the full-time duties of your occupation during the 90-day period immediately before the date of this application? Yes No

Other Insurance Information:

Do you have any Business Overhead Expense Insurance in force or pending in this or any other company? Yes No

If yes, please 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: \$ _____

Beneficiary (Print Full Name & Relationship) _____

Elimination Period: 30 Day 45 Day

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?	<input type="checkbox"/>	<input type="checkbox"/>
B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
C. Colitis, ulcer, liver, kidney disease, or any disease or disorder of the digestive, urinary or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is anyone proposed for coverage now pregnant? If yes, Name: _____ When is the baby due? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are there any medical complications?	<input type="checkbox"/>	<input type="checkbox"/>

*"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.

Question Number	Disorder or Reason	Dates To/From	Give details for any "Yes" answer. Explain the nature of illness, number of attacks, duration, severity, treatment, names and addresses of physicians, hospitals, and date of full recovery

(Attach sheet of paper if additional space is needed.)

Payment Option Selection: Choose only one: first premium payment must be made with check.

Option 1: Direct Billing: Following your initial billing, you will be billed twice a year on April 1 and October 1.

Option 2: Electronic Funds Transfer: I request and authorize the NSPE Member Insurance Program to make withdrawals against the account specified on the attached voided check, statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Bill Payor Protection Plan (Enclose a VOIDED check or deposit slip, as applicable).

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT

DATE

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. 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 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 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 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 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 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

FRAUD WARNING

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION 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, UNCOMPLETE, 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 ALLOWEED BY STATE LAW.

Underwritten by:



Hartford Life and Accident
Insurance Company
Simsbury, CT 06089

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