SEND NO MONEY NOW!

amta
american massage therapy association

American Massage Therapy Association

Group Disability Income Insurance Application

THE HARTFORD

Hartford Life and Accident Insurance Company
Hartford, Connecticut 06155

Policy #AGP-5874

1. POLICYHOLDER: American Massage Therapy Association Policy #AGP-5874

Member Number:

2.

Member Name: (First, Middle, Last)

Street: City State Zip Code

Phone No.: ( ) - E-mail Address:

Date of Birth: Month / Day / Year Place of Birth: State, Country

Male: ◯ Female: ◯ Height: ft. in. Weight: lb.

Beneficiary — Print full name & relationship to you

Name: Relationship:

The Member will be the beneficiary for any Dependent Coverage desired.

3.

Spouse's Name: (First, Middle, Last)

Street: City State Zip Code

Phone No.: ( ) - E-mail Address:

Date of Birth: Month / Day / Year Place of Birth: State, Country

Male: ◯ Female: ◯ Height: ft. in. Weight: lb.

4. COVERAGE REQUESTED:

Member Coverage:

◯ $400 ◯ $1,000 ◯ $1,500 ◯ $2,000 ◯ $2,500 ◯ $3,000 ◯ $3,500 ◯ $4,000

Elimination Period: ◯ 45 days ◯ 60 days ◯ 90 days ◯ 180 days

Spouse Coverage:

◯ $400 ◯ $1,000 ◯ $1,500 ◯ $2,000 ◯ $2,500 ◯ $3,000 ◯ $3,500 ◯ $4,000

Elimination Period: ◯ 45 days ◯ 60 days ◯ 90 days ◯ 180 days

CONTINUED ➡

5. The Monthly Benefit Amount herein applied for must be equal to or less than 70% of your Basic Monthly Pay minus any Other Income Benefits.

6. **PLEASE COMPLETE THE FOLLOWING:**

All questions are answered to the best of my knowledge and belief:

	MEMBER		SPOUSE	
	YES	NO	YES	NO
1. During the last 5 years, have you or your Spouse been diagnosed or been treated for cancer, tumor, high blood pressure, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any disease or disorder of the glands, any lung or respiratory disorder, liver, kidney or genitourinary disorder, alcohol or drug dependency, mental or nervous disorder, impaired sight or hearing, bone, joint, back, muscle or connective tissue disorder, or chronic fatigue syndrome?	○	○	○	○
2. Have you or your Spouse ever been diagnosed or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	○	○	○	○
3. Have you or your Spouse been confined in a hospital, nursing home, sanatorium or similar institution in the last 6 months (excluding maternity)?	○	○	○	○

7. Please review your answers to these questions to be sure that you have answered them fully and truthfully.

I/We understand that coverage will not become effective until the Company grants its underwriting approval and the administrator is in receipt of the first payment of premium. I/We do not receive temporary or conditional insurance coverage just because I/we submit an application.

By signing below, I/we acknowledge that I/we have read and agree to all terms on the reverse of this form.

8.

AUTHORIZATION

I/We hereby certify that I/we have read or have had read to me/us all statements and answers in this application, and in any other application or medical form required by Hartford Life and Accident Insurance Company, and that they are full, complete, and true to the best of my/our knowledge and belief. I/We understand that any material misrepresentations in this application could cause a claim to be denied under any insurance issued based on this application. I/We 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/We also agree that a copy of this application shall be attached to and form a part of any certificate issued. I/We also understand that the Company may request whatever additional evidence of insurability it needs.

Subject to the deferred effective date provision, I/We understand that coverage will not become effective until the Company grants its underwriting approval. I/We do not receive temporary or conditional insurance coverage just because I/we submit an application and pay the first premium.

I/We 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/our physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status except drug and alcohol treatment information.

Hartford Life and Accident Insurance Company will use the information to decide if and to what extent we are eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I/We understand the Medical Information Bureau, Inc. will release records or information only to Hartford Life and Accident Insurance Company.

I/We authorize Hartford Life and Accident Insurance Company to give information about me/us to: its reinsurer(s), any other insurance company to whom I/we 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/We authorize Hartford Life and Accident Insurance Company, or its reinsurers, to make a brief report of my/our personal health information to Medical Information Bureau.

I/We understand that upon written request I/we 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/our coverage or, if no coverage has been issued one (1) year from the date of this application.

CONTINUED

I/We understand that a photocopy of this form is as valid as the original, and that I/we have a right to receive a copy of this form upon request.

I/We certify that I/we have received the Notice of Insurance Information Practices. I/We agree that this document and all its contents shall form a part of my/our enrollment request for group benefits.

PRE-EXISTING CONDITIONS LIMITATION: I/We understand that any injury or sickness, diagnosed or undiagnosed, for which I/we have received medical advice or treatment in the 12 month period prior to my/our effective date of coverage will not be covered until I/we have gone 12 months ending on or after my/our effective date of coverage without medical advice or treatment for that condition, or until 2 Years after my/our 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/our certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation.

I/We further understand that any condition excluded or limited by the Policy or by a Health Waiver attached to my/our certificate will not be covered under this Policy at any time.

Member's signature (Sign name in full)

Required

Date

Required

Spouse's signature (if applying)

Required

Date

Required

FRAUD WARNING STATEMENT

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 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

AGIA
AFFINITY

AMTA Optional Insurance Program
P.O. Box 26860
Phoenix, AZ 85068
1-866-803-6773
Administered by
A.G.I.A., Inc.

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If you answered “Yes” to any of the above questions, provide the details below to include the condition, diagnosis, number of episodes, duration, severity, date of last symptom, current status, treatment, medications and dosages, test results, any further treatments planned and the medical professionals and hospital’s name, address and phone number. If additional space is needed, provide additional sheet with details.

Question Number, Condition, Dates and Details	Name of Family Member	Medical professional’s name, full address and phone number

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