Evidence/Proof of Insurability for Group Life Insurance

This form is for residents of: AL, AK, AZ, CA, CT, DE, HI, ID, IL, KY, LA, MA, MI, MS, MT, NE, NV, NH, NM, NC, ND, OH, OK, Puerto Rico, RI, SC, TN, UT, VT, VA, WA, Washington DC, WV, and WY.

Evidence/Proof of insurability is required in any of the following situations:

- An employee/member is applying during the enrollment period, but is requesting more than the amount guaranteed by the policy;
- The policy is replacing coverage from a prior carrier, and the employee/member is requesting more coverage than he/she had with the prior carrier, or is electing coverage for the first time;
- An employee/member is a late applicant, applying after the enrollment period;
- An employee/member is asking for an increase in coverage.

Instructions for Employer/Benefit Administrator:

1. Please complete Part 1 of the form as applicable to the plan(s) requiring evidence of insurability. Type or print clearly with blue or black ink. We cannot accept faxed or photocopied applications, applications completed in pencil, or customized applications that have not been approved by the EOI Department. Enrollment forms are not considered EOI Applications.

2. Upon completion, please give to the employee for completion of Part 2 & 3.

Instructions for Employee/Member:

1. It is required that you be given the “NOTICE TO PROPOSED INSURED REGARDING MEDICAL INFORMATION BUREAU & INFORMATION PRACTICES.” Please read it carefully and keep it for your records.

2. Please complete Part 2 & 3 of the form. Incomplete information will result in delays. Type or print clearly with blue or black ink. We cannot accept faxed or photocopied applications, applications completed in pencil, or customized applications that have not been approved by the EOI Department. Enrollment forms are not considered EOI Applications.

3. Information regarding your spouse and dependents needs to be filled out if you are requesting Spouse or Dependent Life coverage. Otherwise, it can be left blank.

4. The beneficiary information only applies to your own Basic Life, Supplemental Life, or Voluntary Life coverage. You, the employee, are the beneficiary of any Spouse or Dependent Life coverage requested. You will probably need to contact your benefits administrator or Human Resources Department if you are changing beneficiaries. If you have an irrevocable beneficiary, then your irrevocable beneficiary must sign the form. If you live in AZ, CA, ID, LA, NV, or NM and you name someone other than your spouse as beneficiary, then your spouse must sign the form.

5. If you make any changes to the application, please initial and date next to the change(s).

6. Keep this portion of the form, and be sure to keep a copy of the completed application.

Mail to:

The Hartford
Group Medical Underwriting
PO Box 2999
Hartford, CT 06104-2999
NOTICE TO PROPOSED INSURED REGARDING MEDICAL INFORMATION BUREAU & INFORMATION PRACTICES

In order to properly underwrite and administer your application for insurance coverage, the Company and The Hartford must collect certain information concerning your insurability. You are our most important source of information, but the Company and The Hartford may also contact other sources, including medical professionals and institutions, employers and other insurance companies. In certain instances, the Company and The Hartford may also need to conduct an investigative consumer report. This usually takes the form of a personal interview that is conducted with you in person or over the telephone. If an interview is conducted with someone other than you, the Company and The Hartford will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. All information regarding your insurability will be treated as confidential.

You have the right to be told about, and to see (and copy if you wish), items of personal information about you which appear in the files of the Company and the Hartford, including the nature and scope of information contained in investigative consumer reports. You also have the right to seek correction, amendment or deletion of information you believe to be inaccurate.

The Company and The Hartford may also make information in its files available to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

The Company and The Hartford may make a brief report regarding your insurability to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.
Part 1: Employer/Association Information

<table>
<thead>
<tr>
<th>Employer/Association Name</th>
<th>Group Policy #(s):</th>
<th>Contact Name</th>
<th>Phone Number</th>
<th>Contact’s Email Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer/Association Address</th>
<th>City</th>
<th>State Abbr.</th>
<th>Zip Code</th>
<th>Employee’s Annual Earnings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employee’s/Member’s Date of Full Time Employment</th>
<th>Occupation</th>
<th>Class</th>
</tr>
</thead>
</table>

1. Is application being made for amounts above the amount guaranteed by the policy? [ ] Yes [ ] No

2. Is this policy replacing coverage from a prior carrier? [ ] Yes [ ] No
   If yes, was the employee/member covered under the prior carrier for the same amount he/she is requesting? [ ] Yes [ ] No

3. Is application being made as a late entrant? [ ] Yes [ ] No
   If yes, the Guaranteed Amount of coverage will not apply.

Maximum Amounts of Coverage Available According to the Policy

<table>
<thead>
<tr>
<th>Basic</th>
<th>Supplemental/Voluntary</th>
<th>Spouse</th>
<th>Child</th>
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</thead>
<tbody>
<tr>
<td>$</td>
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</table>

Employee/Member Amounts of Coverage

<table>
<thead>
<tr>
<th>Employee/Member Basic</th>
<th>Amounts of Coverage Provided by Employer/Association</th>
<th>Current Amount Inforce (if any)</th>
<th>Guaranteed Amount for New (Timely) Applicants Only</th>
<th>Total Amount Needing Underwriting Approval</th>
</tr>
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<table>
<thead>
<tr>
<th>Employee/Member Supplemental/Voluntary</th>
<th>$</th>
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<table>
<thead>
<tr>
<th>Spouse Basic</th>
<th>$</th>
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<table>
<thead>
<tr>
<th>Spouse Supplemental</th>
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<table>
<thead>
<tr>
<th>Child</th>
<th>$</th>
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</table>

Part 2: Employee/Member Information

<table>
<thead>
<tr>
<th>Full Legal Name</th>
<th>Daytime Phone #</th>
<th>Residential Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>(_____)</th>
<th>Daytime Phone #</th>
<th>Residential Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>(_____)</th>
<th>Evening/Alternate Phone #</th>
<th>Gender</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>State of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Spouse Full Legal Name</th>
<th>Gender</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>State of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Children’s Names</th>
<th>Gender</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>State of Birth</th>
</tr>
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<table>
<thead>
<tr>
<th>Primary Beneficiary</th>
<th>Name</th>
<th>Social Sec. #</th>
<th>Relationship</th>
</tr>
</thead>
</table>

Full Address

The written consent is required of any irrevocable beneficiary, or of your spouse if you are a resident of AZ, CA, ID, LA, NV, or NM and you name someone other than your spouse as beneficiary. By signing this form, I consent to the beneficiary named above:

Signature of Spouse or Irrevocable Beneficiary: __________________________
Print Name: __________________________
Date: __________________________

Administered by:
Underwriting Company (herein called the “Company”):
☐ CNA Group Life Assurance Company* ☐ Continental Assurance Company

Group Life Evidence/Proof of Insurability

PLEASE TYPE OR PRINT CLEARLY WITH BLUE OR BLACK INK

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ORIGINAL TO THE HARTFORD

(Revised 3/2004) SB127329E1
### Part 3: Employee and Dependent Statement of Health

(For employee &/or spouse to complete – supply information only for insured and/or dependent(s) to be covered)

<table>
<thead>
<tr>
<th></th>
<th>Employee's: Height</th>
<th>Weight</th>
<th>Spouse's: Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Height</td>
<td></td>
<td>Height</td>
<td></td>
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<tr>
<td>1a.</td>
<td>Spouse's: Height</td>
<td></td>
<td>Weight</td>
<td></td>
</tr>
</tbody>
</table>

2. Have you or any of your dependents ever had any life or health insurance postponed, rated, ridered, declined, cancelled or had reinstatement refused? □Yes □No
   If yes, give dates, company name and reason: ____________________________

3. To the best of your knowledge and belief, have you or any of your dependents ever been medically treated for or medically advised of any of the following:
   a. Epilepsy, or any nervous, mental or emotional disorder? □Yes □No
   b. Abnormal blood pressure, heart attack, heart murmur; any other blood, heart or circulatory disorder, or any immune deficiency disorder? □Yes □No
   c. Any lung or respiratory disorder? □Yes □No
   d. Ulcer of the stomach or duodenum, any rectal disorder, gall bladder or any other digestive disorder? □Yes □No
   e. Kidney or any other urinary disorder, albumin, pus or sugar in urine, disorder of the prostate or genital organs? □Yes □No
   f. Thyroid disorder, diabetes, gout, any eye or ear disorder, any discolored areas or lesions of the skin or mouth? □Yes □No
   g. Arthritis, rheumatism, any disorder of the back, spine, neck, bones, muscles or joints? □Yes □No
   h. Cancer, tumor, growth, enlarged lymph nodes or any skin disorder? □Yes □No
   i. Alcoholism, drug dependency or substance abuse? □Yes □No

4. To the best of your knowledge and belief, have you or any of your dependents in the last 5 years ever had any medical advice or treatment, physical impairment, deformity, sickness, operation, injury or check-up other than admitted in question 3, or are you or any of your dependents pregnant at this time? □Yes □No

5. Please complete the following for each "yes" answer to questions 3 and 4:

<table>
<thead>
<tr>
<th>Question # &amp; Letter</th>
<th>Person</th>
<th>Medical Condition</th>
<th>Treatment</th>
<th>Dates From – To</th>
<th>Results</th>
<th>Doctors or Hospitals (Names and Addresses)</th>
</tr>
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</tbody>
</table>

6. Are you currently working your regular workweek? □Yes □No
   If no, explain: ____________________________

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**YOU MUST SIGN BOTH THE ACKNOWLEDGMENTS SECTION (PART 4) AND THE AUTHORIZATION SECTION (PART 5) IN ORDER FOR US TO PROCESS YOUR APPLICATION**

### PART 4: ACKNOWLEDGEMENTS

I ACKNOWLEDGE having received and read, or had read to me, the Notice To Proposed Insured Regarding Medical Information Bureau & Information Practices (where applicable).
I CERTIFY that I have read, or had read to me, the completed application. I UNDERSTAND AND AGREE that the statements in this application are complete and true to the best of my knowledge and belief and that this application will form a part of the contract of insurance.
I UNDERSTAND that the statements in this application are considered representations and not warranties, and that the insurance for which I am applying, if issued, shall be based on these statements. If this application is accepted, I understand that my insurance will take effect in accordance with the provisions of the insurance contract.

**Caution Notice:** If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind your coverage, subject to the incontestability provisions in the insurance contract.

**Fraud Warning Notice:** ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**Date**

**Employee's Signature**

**Spouse’s Signature (if applying)**

* The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company, Hartford Life Insurance Company and CNA Group Life Assurance Company (pending state approval of name change to “Hartford Life Group Insurance Company”).

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PART 5: AUTHORIZATION TO OBTAIN INFORMATION

Underwriting Company (herein called the “Company”):
- CNA Group Life Assurance Company *
- Continental Assurance Company

“Information Provider” as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, clearinghouse, insurance or reinsuring company, (including affiliated insurance companies of the Company and The Hartford), agent, broker, service provider, Medical Information Bureau, Inc. (MIB), credit bureau or other consumer reporting agency, employer or the Veterans Administration.

“Information” received from an Information Provider may include advice, diagnosis, prognosis, treatment or care of any physical or mental condition concerning me, including information about HIV or AIDS, drug or alcohol abuse or mental illness (except psychotherapy notes) and/or financial, consumer report, or any other non-medical information or personal information concerning me.

I AUTHORIZE any Information Provider to give the Company and The Hartford any and all Information regardless of any previous restriction or limitation on disclosure of such Information. In order to expedite my request, I further authorize an Information Provider (except MIB) to release Information to the Company’s and The Hartford’s agents, brokers, service providers, its reinsurers, or any other third party retained by the Company and The Hartford to collect and transmit such Information.

I UNDERSTAND that the Information obtained by use of this Authorization is at my request and will be collected by the Company and The Hartford to determine eligibility for insurance. I understand that this Authorization shall remain valid for twenty-four months from the date shown below. I understand that if I do not sign this Authorization, the Company and The Hartford may not accept my application for insurance. I also understand that my refusal to sign this Authorization does not affect my ability to receive treatment from my physician or other health care provider.

I UNDERSTAND that the Company and The Hartford may maintain or have access to personal information acquired separately through any of my previous insurance applications with the Company and The Hartford or its affiliates for insurance even in instances where insurance was not placed with me. I authorize the Company and The Hartford to use or disclose such information in consideration of my current application for insurance.

I UNDERSTAND that I may revoke this Authorization at any time by providing written notice to the Company and The Hartford, except: (i) to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation, or (ii) to the extent that this authorization was provided as a condition of obtaining insurance coverage and other law provides the Company and The Hartford with the right to contest a claim for coverage under the policy or the insurance coverage under the policy itself.

I UNDERSTAND that Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I UNDERSTAND that I may request to receive a copy of this Authorization and I agree that a photographic copy of this Authorization shall be as valid as the original.

Date         Employee's Signature          Spouse’s Signature (if applying)

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ORIGINAL TO THE HARTFORD GROUP BENEFITS UNDERWRITING; COPY TO APPLICANT