Limited, One-Time Offer Exclusively for New NAIFA Members

GUARANTEED ISSUE*

Group Disability Income Insurance Plan

(Underwritten By Hartford Life and Accident Insurance Company, Simsbury, CT 06089)

Offer Expires 30 Days from Postmark

Dear New NAIFA Member,

You can enroll now for as much as a $1,500 monthly disability coverage, subject to Pre-existing condition limitations. As a new NAIFA member, age 55 or under, you are eligible for guaranteed issuance* of valuable coverage with the NAIFA Advantage Plus Group Disability Income Insurance Plan.

Act now…before the offer expiration date…and you'll receive Guaranteed Issue* Disability Income Insurance Protection, based on your age when you enroll:

Age 45 and under	$1,500 Monthly Benefit
Ages 46 to 50	$1,000 Monthly Benefit
Ages 51 to 55	$500 Monthly Benefit

For this special Guaranteed Issue* coverage the benefit duration is 2 years for both covered injury and sickness and the elimination period is 90 days. You may not have any other Disability Insurance in force when you enroll. To determine your rates, simply use the chart below. All other features, provisions and exclusions described are included in the Guaranteed Issue* coverage.

The rates shown are per $100 of your monthly benefit.
For example a $1500 benefit for a 36 year old: 1500/ 100 = 15 x $.35 = $5.25 monthly premium.

Age	Under 35	35-39	40-44	45-49	50-54	55
Rates per $100 of insured monthly benefit	$.25	$.35	$.42	$.71	$1.15	$2.11

Amount shown is per month. Rates and/or benefits may be changed on a class basis.
Rates are based on the attained age of the Insured Person and increase as you enter each new age category.

It's easy to enroll. Simply…

- Complete and mail the Enrollment Form below in the enclosed postage-paid envelope, OR
- Enroll online at www.kelsey.com/naifa, OR
- Call (800) 366-5656, please choose Option 3

Be sure to take advantage of this valuable NAIFA new member benefit now. The total of your Guarantee Issue* amount cannot exceed 60% of your basic monthly earnings.

Sincerely,

Teri R. Shaw
Director, Member Benefits, Affinity Programs

Mark Kelsey
CA Lic. #: 0630421

Please refer to reverse side of this page for more information (including costs, exclusions, limitations, reduction of benefits and terms of coverage).

* This policy is guaranteed issue/acceptance, but it does contain a pre-existing condition exclusion. Please refer to reverse side of this page for more information on exclusions and limitations, such as pre-existing conditions.

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- Detach Here -

NAIFA NEW MEMBER GUARANTEED ISSUE* GROUP DISABILITY INCOME INSURANCE ENROLLMENT FORM

Underwritten by Hartford Life and Accident Insurance Company, Simsbury, CT 06089
(Offer Expires 30 Days from Postmark)

AGP-5825

Name: _____ Birth Date: _____

Address: _____ City: _____ State: ____ ZIP: _____

Phone: _____ FAX: _____ Membership #: _____

Email: _____

Member Plan Option: 90 Day Waiting Period
Select the benefit amount of your choice in increments of $100, up to $1,500.
Monthly Benefit Amount: $_____

I hereby enroll with The Hartford Life and Accident Insurance Company for coverage under the Group Disability Income Insurance Income Plan. I represent that I am under age 55, work at least 30 hours a week, and that the statements above are true and complete to the best of my knowledge and belief and are binding on any person. By selecting coverage under this plan, I recognize that the benefit amount cannot exceed 60% of my basic monthly pay (minus any Other Income Benefits). I understand that this program will not cover pre-existing conditions (conditions for which I received medical advice or treatment within 24 months of this coverage) until 12 treatment-free months have passed (ending on or after my effective date) or until the coverage has been in effect for 2 years.
*This policy is guaranteed acceptance, but does contain a Pre-Existing Condition Limitation. Please refer to the Features and Provisions on the next page for more information on exclusions and limitations, such as Pre-Existing Conditions.

X_____ _____
Signature Date

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NAIFA New Member Guaranteed Issue Group Disability Income Insurance Plan

Monthly Benefits
The Total Disability benefit will begin to accrue on the day after the Elimination Period ends. The Total Disability benefit will be paid in the amount elected and approved, reduced by other income benefits as described below.

Limited Monthly Benefits
If you are Totally Disabled due to mental illness, alcoholism or substance abuse, the maximum payment period will be reduced to 2 years during your lifetime, unless you are confined in a hospital or other institution licensed to provide care and treatment for that disability.

Limited Monthly Benefits for Pre-existing Conditions
The policy will not pay a benefit for any loss or period of Total Disability which: 1) begins during the first 24 months of coverage; and 2) is a result of a Pre-existing Condition, unless such Total Disability begins after you have been free of medical care for the condition for a 12 month period ending any time on or after your effective date of coverage.

Successive Periods of Disability
Successive periods of disability will be considered one period of disability if the periods of disability are due to the same or related medical causes; and separated by less than 6 months during which You are Actively at Work.

Concurrent Disability
Benefits during any Period of Disability as the result of:
1. more than one Sickness; or
2. more than one Injury; or
3. both Sickness and Injury;

will be considered the same as if the disability resulted from only one cause.

Exclusions
No monthly benefit will be paid for disability due to: intentionally self-inflicted injury, suicide or attempted suicide, while sane or insane; pregnancy or childbirth, except complications of pregnancy; war or act of war, whether declared or not; and your commission or attempted commission of a felony.

Termination
Your coverage will end on the earliest of: 1) the date the policy terminates; 2) the date the policyholder withdraws its sponsorship of, or cancels, the policy; 3) the premium due date on or next following the date you attain the policy age limit; 4) the date you cease to be Actively at Work, except due to disability covered by the policy; 5) the premium due date any required contribution is not made, subject to the individual grace period.

Eligibility
This Guaranteed Issue offer is available to New Members under the age 55, Actively at Work on a full time basis (at least 30 hours a week), and who reside in the United States.

Effective Date:
When You give Us a satisfactory application and pay the required premium for coverage, then You will become covered under The Policy on the later of:
1. The Policy Effective Date;
2. the first day of the month on or next following the date We receive the request; or
3. if evidence of insurability is required, the first day of the month on or next following the date:
   a) we determine that You are insurable;
   b) with respect to the Guaranteed Issue Plan, the date We determine that You are insurable only under such plan;

subject to the Deferred Effective Date provision.

Deferred Effective Date:
If on the date You are to become covered:
4. under The Policy;
5. for increased benefits; or
6. for a new benefit;

and You are not Actively at Work on that date, coverage will not begin until the first day of the month on or next following the date You are Actively at Work for 1 month(s).

Survivor Income Benefit
Increase Your Family's Protection In Case Of Death
Included in your Disability Income Plan is the Survivor Income Benefit, which is paid to your designated beneficiary if you were receiving a Monthly Disability Benefit for at least 12 months at the time of your death. Your benficiary would receive a monthly benefit amount equal to 75% of the last Monthly Disability Benefit paid to you for a maximum period of 12 months.

Other Benefits
· Disabled and Working: partial benefits available while you're working and disabled
· Rehabilitative Employment Benefit: learn new skills while receiving disability payments
· Cost of Living Adjustment Benefit: if you have been Disabled for 12 consecutive months and continue receiving disability payments, your Monthly Benefits will see a 3% increase each January 1st to help with the rising cost of living.

CA Offset Disclaimer:
This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the policy:

Insured's monthly predisability earnings	$3,000
Long term disability benefits percentage	x 60%
Unreduced maximum benefit	$1,800
Less Social Security disability benefit per month	-$900
Less state disability income benefit per month	-$300
Total amount of long term disability benefit per month	$600

Offset Provision
The benefit amount payable as the result of the Insured Person's Total Disability will be the lesser of;
1. the Monthly Benefit; or
2. 60% of the Insured Person's Pre-Disability Earnings less any Other Income Benefits available from any government programs, including those for which the Insured Person could collect but did not apply (i.e. Social Security, Worker's Compensation, etc).

The maximum benefit amount will also be reduced by:
3. any Other Income Benefits available from other group disability or retirement plans; and
4. any other income from employment, including commissions actually paid to the Insured Person.

Under these circumstances, the benefit is reduced so that the total income from such sources does not exceed
70% of the Insured Person's Pre-Disability Earnings.

However, if the Insured Person's Monthly Benefit would reduce to less than $50 per Month due to Other Income Benefits, then the minimum Monthly Benefit under The Policy will be $50 per month.

Actively at Work Requirement
You must be Actively at Work on the date insurance is to take effect. If you are not, insurance will not take effect until the date you resume such work.

Definitions
Total Disability or **Totally Disabled** means disability which:
1. During the Elimination Period and the first 24 months during which the total disability benefits are payable, wholly and continuously prevents you from performing the essential duties of your occupation; and
2. After that, wholly and continuously prevents you from engaging in any occupation.

Elimination Period means the number of consecutive days at the beginning of any one period of Total Disability which must elapse before benefits are payable.

Pre-existing Condition means any disability, diagnosed or undiagnosed, for which medical care is received by you: 1) within the 12 month period prior to the date your insurance starts; or 2) with respect to the limitation for any increase in coverage, within the 12 month period prior to the effective date of your increase in coverage.

Pre-disability Earnings means, if You are self-employed, Your average net monthly income (gross revenues less business expenses) from:
1. the personal practice of Your profession; or
2. personal conduct of Your main business.

This average is based on net income for:
1. 12 months; or
2. 24 months;

whichever produces the higher average, before the determination is made. If You have been self-employed for less than 12 months, it is based on the whole time You were self-employed. If Your practice is incorporated, net income includes the cost to Your company of fringe benefits and Your share of total surplus. Income does not include investment returns, rents, royalties, and the like income which is not directly produced from Your current work.

Pre-disability Earnings means, if You are not self-employed, Your regular monthly rate of pay, includes Commissions, but not bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date immediately prior to the last day You were Actively at Work before You became Disabled

Actively at Work means you are performing the essential duties of your occupation for wage or profit on a full-time basis (at least 30 hours per week).

This brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Hartford Life and Accident Insurance Company detail exclusions, limitations, and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder, Hartford Unsponsored Group Insurance Trust. This program may vary and may not be available to residents of all states.
Kelsey National Corporation is the Plan Administrator and Insurance broker that administers the insurance plan on behalf of the Hartford Life and Accident Insurance Company for the benefit of the Group Policyholder. Kelsey National is compensated for the placement of insurance and for the services it provides to customers on behalf of the insurance company, in addition to other compensation it may receive.

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Disability benefits received from coverage paid for by the insured are normally tax-free. Consult your tax advisor for specific details

Underwritten By Hartford Life and Accident Insurance Company, Simsbury, CT 06089
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

PLEASE INDICATE YOUR PAYMENT METHOD:

I WISH TO USE AUTO PAY (ADD $1.00 ADMINISTRATION FEE)
I have enclosed a VOID check and **completed the Authorization below**.
Please bill me: ◯ Annually ◯ Semi-annually ◯ Quarterly ◯ Monthly

PLEASE BILL ME DIRECTLY (ADD $2.00 ADMINISTRATION FEE)
My check is enclosed in the amount of $ _____, payable to **THE ASSOCIATION TRUST**.
Please bill me: ◯ Annually ◯ Semi-annually ◯ Quarterly ◯ Monthly

AUTO PAY AUTHORIZATION FORM:

ATTACH VOIDED CHECK HERE

Name of Account Holder _____

I hereby authorize Kelsey National Corporation, hereinafter called "COMPANY", to initiate monthly debit entries to my checking account at the financial institution (named below), hereinafter called "FINANCIAL INSTITUTION", and to debit the same to such account.

_____
Name of Financial Institution

_____
Branch City State Zip

This authorization is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it. I understand that if there are insufficient funds in my account when it is automatically debited, Kelsey National Corporation will convert my account to one that is direct billed to me quarterly.

X _____ _____
Authorized Signature *Date*