NAIFA℠

THE HARTFORD

Who will provide for your family if you can't?

Apply now for the NAIFA Advantage Plus
Disability Income Insurance Plan

- Collect up to 60% of your monthly income.
- Commissions are included in income calculations.
- Benefit from NAIFA group rates.
- Help protect your spouse's income, too.

Apply online
www.kelsey.com/naifadisability

Dear NAIFA Member,

Did you know that over half of the 36 million Americans classified as disabled are in their working years (from 18 to 64)?[1]

That's why it's so important to help protect your most important asset—your income. If you become sick or injured and can't work, you can rest assured you'll still have cash to help provide for your family.

Imagine what would happen if you suffer a heart attack or back pain that prevents you from earning an income. How long would you be able to pay the mortgage, your health insurance, and all your everyday expenses? Would you have to use up your savings? Borrow from family?

67% of workers in the private sector have no long-term disability insurance.[2]

As a NAIFA member, you can help protect your family, your finances and your future with the **NAIFA Advantage Plus Disability Income Insurance Plan.**

Save time—we did the research for you.

NAIFA is a membership organization working in your best interest. After reviewing different policies, we chose The Hartford[3] and Kelsey National Corporation, the Plan Administrator, to bring this coverage to you. You get protection you can count on—plus benefits designed especially to meet the needs of NAIFA members.

- **Collect richer benefits**—commissions are included in income calculations.

- **Competitive group rates**—you benefit from the buying power of NAIFA membership.

- **Enjoy portable coverage**—your protection stays with you. The NAIFA Advantage Plus plan stays with you if you change jobs, are between jobs, or work for yourself. It's an extra measure of security you can count on, no matter what the future holds.

And it's because you don't know what the future holds that this protection can be so important. No matter what your age or lifestyle, an illness or accident can happen anytime. In the blink of an eye your income could stop—along with your ability to provide for yourself and your loved ones. Don't wait until it's too late. Act now to help get the financial protection you need.

Because this protection is so important, we've made it affordable and easy to apply, subject to approval. You can choose benefits and features to fit your needs and budget. And you have a choice of convenient payment options: annual, semi-annual, quarterly, monthly—even auto-pay. So don't wait. Apply online right now.

As a NAIFA member, you have access to this quality coverage and competitive group rates. Take advantage of this valuable membership benefit today.

Apply now online:

www.kelsey.com/naifadisability

Or call a NAIFA Benefit Representative for more information:

(800) 366-5656, Ext. 504

Sincerely,

Teri Shaw
Director of Member Benefits
NAIFA

Mark Kelsey
President
Kelsey National Corporation
Ca Lic. #0630421

P.S. Please see the enclosed brochure to learn more. Then respond by the date on the front of this letter. For extra convenience, apply online at **www.kelsey.com/naifadisability**. Please read the enclosed materials for more information (including costs, exclusions, limitations and terms of coverage) on this plan.

[1]"Disability Statistics." www.disabilitycanhappen.org (citing US Census Bureau). Council for Disability Awareness. www.disabilitycanhappen.org/chances_disability/disability_stats.asp. 8/27/2012.
[2]Social Security Administration, Fact Sheet March 18, 2011.
[3]The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

DISABILITY INCOME INSURANCE PLAN

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Simsbury, Connecticut 06089

THE HARTFORD

Need Help? Call a NAIFA Benefit Representative at (800) 366-5656, Ext. 504

STEP 1: SELECT YOUR PLAN TYPE

PLAN BENEFITS	PLAN 1	PLAN 2	PLAN 3
Benefit Duration* Sickness/Injury	2 years / 2 years	5 years / 5 years	to age 65 / to age 65
Maximum Insured Pre-disability Earnings	You may insure 60% of first $10,000 of your Pre-disability Earnings. *(And your spouse may insure his/her earnings.)*		
% Earnings Payable	Up to 60% of your Pre-disability Earnings.		
Maximum Monthly Benefit	Choose $500 to $6,000 (in increments of $100).		
Elimination Period	You choose: 30, 60, 90 or 180 days.		
Waiver of Premium	Yes, after benefits payable for 6 continuous months.		
24-Hour Coverage	Yes, on and off the job.		
Pre-existing Condition Coverage	Full after 24 months insured or 12 continuous months without treatment while insured.		
Survivor Income Benefit	Pays benefits to beneficiary if member/spouse dies while receiving disability income.		

**If total disability begins before age 60, benefits are paid for 2 years, 5 years or to age 65, as elected.*
If total disability begins on or after age 60, benefits are paid for up to 2 years, but not beyond age 70.

STEP 2: CHOOSE A WAITING PERIOD

Rates per $100 of insured monthly benefit
(Rates for Disability Income Benefit increase as you change age groups.)

	Attained Age	30-Day Elimination	60-Day Elimination	90-Day Elimination	180-Day Elimination
Plan 1	Sickness and Injury: 2-year Benefit Period				
	Under 35	.36	.30	.25	.22
	35-39	.50	.42	.35	.31
	40-44	.61	.50	.42	.37
	45-49	1.03	.85	.71	.63
	50-54	1.67	1.38	1.15	1.02
	55-59	3.06	2.54	2.11	1.86
	60-64*	4.84	4.02	3.34	2.96
	65-69*	7.96	6.61	5.49	4.86
Plan 2	Sickness and Injury: 5-year Benefit Period				
	Under 35	.52	.44	.36	.32
	35-39	.76	.63	.53	.46
	40-44	.97	.80	.67	.59
	45-49	1.70	1.41	1.17	1.04
	50-54	2.82	2.34	1.95	1.72
	55-59	5.35	4.44	3.69	3.27
	60-69*	7.96	6.61	5.49	4.86
Plan 3	Sickness and Injury: to age 65 Benefit Period				
	Under 35	.89	.79	.65	.59
	35-39	1.40	1.16	.97	.85
	40-44	1.74	1.44	1.21	1.06
	45-49	2.97	2.46	2.05	1.81
	50-54	4.36	3.62	3.01	2.66
	55-59	6.40	5.30	4.41	3.90
	60-69*	7.96	6.61	5.49	4.86

**Renewal rates only. 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.*

STEP 3: CALCULATE YOUR MONTHLY PREMIUM

HOW MUCH COVERAGE IS RIGHT FOR YOU?

Take your Pre-disability Earnings up to $10,000 _____
x .60 = $_____
Round down to nearest $100 = $_____
(This is your Maximum Monthly Insured Benefit Amount.)

Your insured monthly benefit can be any amount from $500 to $6,000, in increments of $100, up to your maximum insured monthly benefit.

Enter your desired monthly insured benefit amount _____
Divide desired benefit by 100
to find how many Units you want _____

CALCULATE YOUR PREMIUM

Mulitply your rate (from rate chart above)
by number of Units = $_____
This is your monthly premium.

EXAMPLE

A 35-year-old member with Pre-disability Earnings of $3,000 wants a 60-day elimination period under Plan 1 and $1,800 insured monthly benefit. Member would:

Step 1: Select Plan 1 with a 60-day elimination period
Step 2: Look up Plan 1 rate for a 35-year-old member with a 60-day elimination period (rate per $100 of insured monthly benefit) = $.42
Step 3: Find the premium for $1,800 insured monthly benefit by simply dividing the desired benefit amount ($1,800) by $100. Multiply the rate from the table by this number.

$1,800 divided by 100 = 18
$.42 (rate from table) x 18 = $7.56
Monthly premium for this member is $7.56

FOR YOUR CONVENIENCE

SELECT YOUR PAYMENT SCHEDULE (Please enclose a check for the total amount with your completed application.)

- Choose annual, semi-annual or quarterly direct billing.
- Multiply your calculated monthly rate by 12 (for annual billing), 6 (for semi-annual billing), or 3 (for quarterly billing).
- Add a $2.00 administration fee to each billing period selected.

AUTO - PAY (Please enclose a voided check.)

- To pay premiums monthly, use the convenience of Auto-Pay. Payments will be deducted from your checking account.
- No checks to write.
- No due dates to remember.
- Add $1.00 for administration fee to each billing cycle.

SURVIVOR INCOME BENEFIT

INCREASE YOUR FAMILY'S PROTECTION IN CASE OF DEATH

Included in your Advantage Plus Disability Income Protection 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 1 to help with the rising cost of living.

Policy Form # GBD-1000 A (AGP-5825)

NAIFA Advantage Plus 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.

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 your insurance; 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.

Integration
Your monthly income benefit is reduced by any benefits available from any government plans (i.e. Social Security benefits, Workers' Compensation, etc.). Then, if any benefits are available from other group disability and retirement plans, or any other income from employment, the benefit is reduced so that the total income from such sources does not exceed 60% of your Pre-Disability Earnings.

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 and your spouse's 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 or your spouse attain the policy age limit; 4) the date you or your spouse 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; or 6) with respect to your spouse's coverage, the premium due date he or she is legally separated or divorced from you.

Eligibility
All active, dues paying members of NAIFA and their spouses who:
1. Are under age 60;
2. Reside in the United States;
3. Are Actively at Work on a full-time basis (at least 30 hours per week); and
4. Have been working full-time for at least 30 days before his or her effective date.
5. Spouse is not legally separated or divorced from the eligible member.

When a member and spouse are both eligible members, coverage may not be duplicated by applying as dependents of each other.

Effective Date:
When You or Your Spouse give Us a satisfactory application and pay the required premium for coverage, then You or Your Spouse 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 or Your Spouse are insurable;
   b) with respect to the Guaranteed Issue Plan, the date We determine that You or Your Spouse are insurable only under such plan;

subject to the Deferred Effective Date provision. However, Your Spouse's coverage will not become effective prior to the date Your coverage becomes effective.

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

and You or Your Spouse 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 or he or she are Actively at Work for 1 month.

Evidence of Insurability
A medical application with MIB authorization is required for all monthly benefit amounts and benefit periods; lab work may be required in some cases.

Actively at Work Requirement
You and your spouse, if applying, must be Actively at Work on the date insurance is to take effect. If you and he or she is not, insurance will not take effect until the date the member resumes 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 or your spouse from performing the essential duties of your or your spouse's occupation; and
2. After that, wholly and continuously prevents you or your spouse 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 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 or Your Spouse are not self-employed, Your or Your Spouse's 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 or Your Spouse were Actively at Work before You or Your Spouse became Disabled.

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

NOTICE OF INSURANCE INFORMATION PRACTICES
To properly underwrite and administer your application for insurance coverage, we must collect certain information concerning your insurability. You are our most important source of information, but we may also contact other sources such as medical professionals and institutions, employers and other insurance companies. While all information regarding your insurability will be treated as confidential, in some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

INVESTIGATIVE CONSUMER REPORTS – NOT APPLICABLE TO RESIDENTS OF NEW YORK
As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. You have the right to send a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

PERSONAL HISTORY INTERVIEW
To provide you, our client, with the best possible service, we may also conduct what we call a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the application information is complete. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

MEDICAL INFORMATION BUREAU (MIB) PRE-NOTICE
Information regarding your insurability will be treated as confidential. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, or their reinsurers, may also release information from their files to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

ACCESS, CORRECTION AND DISCLOSURE
You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Also, please be advised that personal and confidential information collected by us may, in certain circumstances, be disclosed to third parties without authorization. A notice providing further description of the circumstances under which information about you may be disclosed and the types of persons and organizations to whom it may be disclosed will be sent to you upon your written request. If you desire further information or access to your personal information, please send your written request to: Hartford Life Insurance Company or Hartford Life and Accident Insurance Company, 200 Hopmeadow St., Simsbury, CT 06089.

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

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:
1) any Other Income Benefits available from other group disability or retirement plans; and
2) 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.

TPA Disclaimer
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 Corporation 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.

Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s), or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience and at no expense to you.

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, reduction of benefits 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. This program may vary and may not be available to residents of all states.

Policy Form # GBD 1000 A (AGP-5825) NBCAOS2012

DISABILITY INCOME INSURANCE APPLICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Simsbury, Connecticut 06089

THE HARTFORD

SECTION 1

Please Print. Use Dark Ink. Do Not Erase. Initial All Changes.		For Office Use: h w
Policyholder: NAIFA GROUP INSURANCE TRUST	Policy No. AGP-5825	Certificate No. (Leave Blank)

SECTION 2

Name: (First, Middle Initial, Last)	○ Male ○ Female	Height: ____ft. ____in.	Weight: _____lb.
Date of Birth (MM/DD/YYYY):	Age Last Birthday:	Place of Birth (State/Country):	
Street:			
City:		State:	Zip Code:
Daytime Phone No.:	Business Telephone:	Email Address:	
Occupation:		Pre-Disability Earnings: $	
Business Address: Street:			
City:		State:	Zip Code:

Beneficiary – Print full name & relationship to you

Name: _____ Relationship: _____

SECTION 3

Spouse's Name: (First, Middle Initial, Last), if applying	○ Male ○ Female	Height: ____ft. ____in.	Weight: _____lb.
Date of Birth (MM/DD/YYYY):	Age Last Birthday:	Place of Birth (State/Country):	
Street:			
City:		State:	Zip Code:
Spouse's Occupation:			
Daytime Phone No.:	Business Telephone:		
Pre-Disability Earnings: $			
Business Address: Street:			
City:		State:	Zip Code:

Beneficiary – Print full name & relationship to you

Name: _____ Relationship: _____

SECTION 4

COVERAGE REQUESTED:

Member Coverage:

○ New Coverage: Monthly Benefit Amount: $_____

○ Change in Coverage: Increase my Monthly Benefit Amount to: $ _____

○ Waiting Period: ○ 30 days ○ 60 days ○ 90 days ○ 180 days

Spouse Coverage:

○ New Coverage: Monthly Benefit Amount: $_____

○ Change in Coverage: Increase my Monthly Benefit Amount to: $ _____

○ Waiting Period: ○ 30 days ○ 60 days ○ 90 days ○ 180 days

SECTION 5

Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company?
○ Yes ○ No If yes, give details:

Name	Company	Monthly Benefit	Benefit Period	Waiting Period	To be replaced? Yes	To be replaced? No
					○	○
					○	○
					○	○

Has anyone proposed for coverage been actively engaged in the full-time duties of his or her occupation (at least 30 hours per week) 30 days before the date of this application? You: ○ Yes ◉ No Spouse: ○ Yes ○ No

Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Pre-Disability Earnings minus any Other Income Benefits?
You: ○ Yes ○ No Spouse: ○ Yes ○ No

SECTION 6

All questions are answered to the best of my knowledge and belief:	Yes	No
1. In the past 10 years has anyone proposed for coverage 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?	○	○
B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system or sleep disorder?	○	○
C. Colitis, ulcer, kidney disease or disorder, or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system?	○	○
D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	○	○
E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands or thyroid?	○	○
F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, muscles or joints, including neck or back disorders?	○	○
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	○	○
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?	○	○
3. Is anyone proposed for coverage now pregnant? If yes, Name:_____ When is the baby due? _____ What was your pre-pregancy weight? _____ Are there any medical complications? _____	○	○

SECTION 7

If you answered "yes" to any of the above medical questions, please explain the details below.

Question Number and Condition	Name of Family Member	Dates	For any question answered "yes," please provide details, your physician's name, full address, and phone number (Required for processing)

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

SECTION 8

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 Hartford Life and Accident Insurance 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; Medical Information Bureau, Inc.; or employer; to give Hartford Life and Accident 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. Hartford Life and Accident 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 Hartford Life and Accident Insurance Company.

I authorize Hartford Life and Accident 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 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 agree that this document and all of its contents shall form a part of my enrollment request for group benefits.

PRE-EXISTING CONDITIONS LIMITATION: 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 one (1) year 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 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.

Notice: I understand that California law prohibits an HIV test from being required or used by Health Insurance Companies as a condition of obtaining health insurance coverage.

SECTION 9

PLEASE INDICATE YOUR PAYMENT METHOD:

I WISH TO USE AUTO-PAY (ADD $1.00 ADMINISTRATION FEE)

I have enclosed a VOIDED 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 *Account Type* *Account Number*

_____

Branch City, State, Zip *Routing Number*

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*

SECTION 10

Member's signature (Sign name in full) _____ Date _____

Required Required

Spouse's signature (if applying) _____ Date _____

Required Required

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.