

# HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza  
Hartford, Connecticut 06155  
(A stock insurance company)



Group Term Life Insurance Enrollment Form  
Members age 60 and younger  
Group Policyholder: The Arc of the United States  
Policy Number: AGL-1935

## SECTION 1

### Member Information

Member's Name:	Association Membership Number:
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<input type="checkbox"/> Are you a Member of the Association?	
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Street:	City:	State:	Zip Code:
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Member's Social Security Number:	Member's Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
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Member Occupation*:	Email Address:	Phone Number:
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## SECTION 2

### Coverage Information

#### Life Insurance

Member: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
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By enrolling for this insurance, do you intend to replace, discontinue or change an existing policy of Life Insurance? If not, simply check "No".  
Member: ☐ Yes ☐ No

**\*Important Note:** You must meet all requirements for professional membership in ARC to enroll for this life insurance coverage.

To enroll: Mail your completed enrollment form to: **ARC GROUP INSURANCE, P.O. BOX 14533, Des Moines, IA 50306**  
Questions? Call: 1-800-503-9230  
Email: [customerservice.service@getamba.com](mailto:customerservice.service@getamba.com)

## SECTION 3

### Confirmation

I acknowledge that I have been given the opportunity to enroll in the Group Term Life Insurance Plan. I also acknowledge that I am age 60 and younger, an ARC Member who meets all requirements for professional membership in the Association and that the above information is true and complete to the best of my knowledge. If I enroll today and want to upgrade coverage at a later date, I may be required to submit Evidence of Insurability.

I understand and agree that insurance will go into effect upon receipt of my first premium payment and this form and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy and certificate. I understand and agree that only the insurance policy and certificate issued to ARC can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form insurance policy and certificate, I agree to be bound by the terms and conditions of the certificate.

The Hartford Financial Services Group, Inc. (NYSE: HIG) operates through its subsidiaries under the brand name, The Hartford®. For additional information, see [www.thehartford.com](http://www.thehartford.com).

Form PA-9928 (2017) (AM) (NY) (Rev-1)

I understand that the policy permits the policyholder to change, reduce, restrict or terminate my rights or benefits under the policy without my consent. Such change, reduction, restriction or termination may occur at a time when a covered person's health status has changed and may affect their ability to procure individual coverage.

**Read your certificate carefully.**

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

I have read the Important Replacement Notice included with the application.

**Member's Signature:**

Date:

**SECTION 4**

**Payment Options**

Automatic Bank Withdrawal (Electronic Funds Transfer):

Name: Banking Institution: Routing Number:

Account Number: Bank Account Type: ☐ Checking ☐ Savings

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If your dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

For your convenience you will be billed quarterly.

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If your dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

**Member's Signature:**

Date:

**For Residents of New York (Not applicable to Life Insurance):**

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.



**DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK**

**IMPORTANT REPLACEMENT NOTICE**

**THIS NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY  
INSURANCE REGULATION NO. 60**

**It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into a paid-up or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to contemplating a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you to decide whether the replacement is in your best interest.**

**I HAVE READ THE IMPORTANT REPLACEMENT NOTICE THAT ACCOMPANIED THIS APPLICATION.**

**Do you intend to replace, in whole or in part, any existing life insurance or annuity?**

**Yes \_\_\_\_ No \_\_\_\_**

**Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_**

**Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_**