

SERFF Tracking Number: HARL-125590467 State: Arkansas
Filing Company: Hartford Life and Annuity Insurance Company State Tracking Number: 38662
Company Tracking Number: LA-1253(08)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Mid America Application for Life Insurance
Project Name/Number: Mid America Application for Life Insurance/LA-1253(08)

Filing at a Glance

Company: Hartford Life and Annuity Insurance Company

Product Name: Mid America Application for Life SERFF Tr Num: HARL-125590467 State: ArkansasLH
Insurance

TOI: L08 Life - Other

SERFF Status: Closed

State Tr Num: 38662

Sub-TOI: L08.000 Life - Other

Co Tr Num: LA-1253(08)

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Authors: Jane Chapman, Roberta
Chu, Barbara Warren, Cynthia
McFetridge

Disposition Date: 04/21/2008

Date Submitted: 04/10/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Mid America Application for Life Insurance

Status of Filing in Domicile: Authorized

Project Number: LA-1253(08)

Date Approved in Domicile: 04/01/2008

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/21/2008

State Status Changed: 04/21/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval is a copy of the captioned form. This is a new form and is intended to replace Life Application form LA-1253(04)Rev which was approved by the Department in 2004.

The application is intended for use with individual universal life insurance policies that were previously approved by your Department as well as policies approved in the future. Variable sections of the application are bracketed to allow us to

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remove products or optional riders that may no longer be offered by the company without re-filing. Refer to the Statement of Variability for a detailed description of variable text. In addition, changes in printing technology may periodically alter slightly form format. We reserve the right to make such changes without re-filing as well as modify company address and officer signatures to reflect current company operations.

The form has achieved a Flesch Score of 45.1. The application has been filed concurrently in our state of domicile, Connecticut, and approved for use on 04/01/2008

We have also enclosed for informational purposes the Fraud Notice previously approved by the Department which contains the required fraud statement and will always be used in conjunction with/attached to the application.

Your prompt review of this submission would be greatly appreciated. Please feel free to contact me if you have any questions

Company and Contact

Filing Contact Information

Barbara Warren, Contact Analyst barbara.warren@hartfordlife.com
200 hopmeadow rd (860) 843-6437 [Phone]
Simsbury, CT 06089 (860) 843-5194[FAX]

Filing Company Information

Hartford Life and Annuity Insurance Company CoCode: 71153 State of Domicile: Connecticut
200 Hopmeadow Street Group Code: 91 Company Type: Life
Simsbury, CT 06089 Group Name: State ID Number:
(860) 547-5000 ext. [Phone] FEIN Number: 39-1052598

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation:
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Hartford Life and Annuity Insurance Company	\$20.00	04/10/2008	19443887

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	04/21/2008	04/21/2008

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Disposition

Disposition Date: 04/21/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Fraud Notice FYI		Yes
Supporting Document	Statement of Variability		Yes
Form	Life Insurance Application		Yes

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Form Schedule

Lead Form Number: LA-1253(08)

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LA-1253(08)	Application/Life Insurance Enrollment Application Form	Initial		45	LA-1253(08) Final.pdf



Hartford Life and Annuity Insurance Company

APPLICATION
FOR
LIFE INSURANCE

Check one:

<input type="checkbox"/> C.P.R.
<input type="checkbox"/> G.I.N.
<input type="checkbox"/> Mortgage

COMPANION FILE WITH: _____
(Name of Primary Insured)

AGENT ADDRESS AND CONTACT INFORMATION (First Name Listed Below Will Be The Servicing Agent)			
Primary Writing Agent/ Agent of Record Name & Address	Phone	GA#	Split %
	Fax	WA#	
	E-Mail	Team Number	
Splitting Agent's Name	GA#	WA#	Split%
Splitting Agent's Name	GA#	WA#	Split%
Splitting Agent's Name	GA#	WA#	Split%
Splitting Agent's Name	GA#	WA#	Split%

AGENT: THIS NOTICE MUST BE REMOVED AND LEFT WITH THE PROPOSED INSURED(S)

HARTFORD LIFE AND ANNUITY INSURANCE COMPANY

**Individual Life Operations Address:
P.O. Box 64271
St. Paul, Minnesota 55164-0271**

NOTICE OF INSURANCE INFORMATION PRACTICES

INVESTIGATIVE CONSUMER REPORTS

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. 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-NOTIFICATION

Information regarding your insurability will be treated as confidential. Hartford Life and Annuity Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life 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, the MIB, upon request, will supply such a company, with the information in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact the MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

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 and Annuity 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 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 and Annuity Insurance Company, 500 Bielenberg Drive, Woodbury, Minnesota 55125.



1. PROPOSED INSURED 1—Complete for all Applications			
a. Name of Proposed Insured 1 (First, Middle, Last)	b. Date of Birth	c. State/Country of Birth	d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
e. Residence Address (Including City, State, and Zip Code)	f. Current Employer's Name and Address		g. Years Employed
h. Social Security Number	i. Current Occupation / Duties		
j. Daytime Phone Number ()	k. Evening Phone Number ()	l. Previous Employer's Name (If employed at current employer less than 2 years)	m. Years Employed
n. Annual Net Income	o. Net Worth		
p. Driver's License Number/State of Issue/Expiration Date OR Passport Number/Issuing Country/Expiration Date (Non-US Citizen only)	q. Previous Occupation / Duties (If employed at current employer less than 2 years)		
2. PROPOSED INSURED 2			
a. Name of Proposed Insured 2 (First, Middle, Last)	b. Date of Birth	c. State/Country of Birth	d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
e. Residence Address (Including City, State, and Zip Code)	f. Current Employer's Name and Address		g. Years Employed
h. Social Security Number	i. Current Occupation / Duties		
j. Relationship to Proposed Insured 1	k. Previous Employer's Name (If employed at current employer less than 2 years)	l. Years Employed	
m. Daytime Phone Number ()			
o. Annual Net Income	p. Net Worth	q. Previous Occupation / Duties (If employed at current employer less than 2 years)	
r. Driver's License Number/State of Issue/Expiration Date OR Passport Number/Issuing Country/Expiration Date (Non-US Citizen only)			
3. POLICY OWNER INFORMATION			
a. Policy Owner Name and Address—Complete if other than Proposed Insured 1		b. Soc. Sec. No. or Tax ID	
		c. Date of Birth	
d. Driver's License Number/State of Issue/Expiration Date OR Passport Number/Issuing Country/Expiration Date (Non-US Citizen only)		e. Relationship to Proposed Insured	
f. Send Billing Correspondence to: <input type="checkbox"/> Proposed Insured 1 <input type="checkbox"/> Policy Owner <input type="checkbox"/> Other (Provide Name and Address)		g. Special Requests	

4. PROPOSED INSURED 1—COVERAGE INFORMATION

UNIVERSAL LIFE INSURANCE - COMPLETE THIS SECTION FOR UNIVERSAL LIFE INSURANCE

Life Solutions II Other _____]

a. Face Amount of Base Policy

\$ _____

b. Death Benefit Option—select one

- Option A Option D
- Option B Option E
- Option C

c. Move-up Option —select one

- 20 Years 5 Years
- 15 Years 0 Years
- 10 Years

[d. **Supplemental Benefits and Riders**

Additional Coverage Rider \$ _____

Death Benefit Option—select one

- Option A
- Option C
- Option E

Children's Insured Rider—select one

(Complete Children's Insured Rider Supplement)

- 1 Unit—\$5,000
- 2 Units—\$10,000
- 3 Units—\$15,000

Disability Waiver—select one

- Waiver of Premium
- Waiver of Mortality

Unemployment Waiver

Additional Purchase Option—select one

- \$25,000
- \$50,000
- \$75,000
- \$100,000

Disability Income Rider \$ _____

(Complete DI Rider Supplement)

Elimination Period _____

Benefit Period _____

Accidental Death Benefit \$ _____

Accelerated Death Benefit
(Complete Policyholder Disclosure Form)

Maturity Extension Rider

Split Option Rider

Other _____]

5. PROPOSED INSURED 2—RIDER COVERAGE INFORMATION

Additional Coverage Rider \$ _____

Death Benefit Option—select one

- Option A
- Option C
- Option E

Waiver of Premium

Disability Income (DI) Rider \$ _____

(Complete DI Rider Supplement)

Elimination Period _____

Benefit Period _____

Other _____]

6. PREMIUM/BILLING INFORMATION—Complete for all Applications

a. Premium payment mode: Annually Semi-Annually Quarterly Monthly Electronic Funds Transfer (EFT form required)
 Single Pay Other _____

b. Planned Modal Premium
 \$ _____

c. Billing Options:
 Electronic Fund Transfer (required for Monthly Mode)
 Draft Date _____
 Direct Billing to Payor of Policy (Annually, Semi-Annually, Quarterly)
 List Bill Group # : _____ Sort: _____

7. BENEFICIARY INFORMATION For multiple beneficiary designations, the death benefit should be designated by percentages and the total must equal 100% (Example: 33^{1/3}% + 33^{1/3}% + 33^{1/3}%). If no percentages are stated, the death benefit will be equally divided among the surviving primary beneficiaries.

Proposed Insured 1—Complete for all Applications

a. Primary Beneficiary(s) Name(s)	b. Soc. Sec. No.	c. Relationship to Proposed Insured	d. % of Death Benefit
e. Contingent Beneficiary(s) Name(s)	f. Soc. Sec. No.	g. Relationship to Proposed Insured	h. % of Death Benefit

Proposed Insured 2

a. Primary Beneficiary(s) Name(s)	b. Soc. Sec. No.	c. Relationship to Proposed Insured	d. % of Death Benefit
e. Contingent Beneficiary(s) Name(s)	f. Soc. Sec. No.	g. Relationship to Proposed Insured	h. % of Death Benefit

8. LIFE AND DISABILITY INSURANCE IN FORCE AND PENDING — Complete for all Applications

Provide Details to "Yes" answers below. Please attach additional sheet if more space is needed.		Proposed Insured 1		Proposed Insured 2	
		Yes	No	Yes	No
a.	Do you have life, annuities and/or disability insurance in force? (If "Yes," provide details below and an additional replacement form may apply.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Is any life and/or disability insurance application or inquiry now pending elsewhere? This would include life insurance bound by a temporary insurance agreement or conditional receipt. (If "Yes," provide details below and an additional replacement form may apply.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Will this insurance replace or change insurance with this company or any other company? This would include insurance that is currently pending but bound by a temporary insurance agreement or conditional receipt. (If "Yes," submit any required state replacement form.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Company _____	Person Insured _____	To Be Replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type: <input type="checkbox"/> Individual <input type="checkbox"/> Business <input type="checkbox"/> Group	Policy Number: _____	Amount: _____
	Year Issued: _____	1035 Exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No

Company _____	Person Insured _____	To Be Replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type: <input type="checkbox"/> Individual <input type="checkbox"/> Business <input type="checkbox"/> Group	Policy Number: _____	Amount: _____
	Year Issued: _____	1035 Exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No

9. GENERAL INFORMATION — Complete for all Applications

Provide details to "Yes" answers in Detail Section below. ATTACH ADDITIONAL SHEET IF MORE SPACE IS NEEDED.		Proposed Insured 1		Proposed Insured 2	
		Yes	No	Yes	No
a.	During the past 5 years, have you seen a physician or health care provider for any reason? If "Yes," please provide the physician or medical facility's name and address, date and reason for visit(s), and results of each visit in the space provided below.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Are you a U.S. Citizen? (If "No," provide details including type of visa below.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Have you ever engaged in or do you plan to engage in any aviation activity other than as a fare-paying passenger? (If "Yes," complete Aviation Supplement.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	In the past two years, did you participate in, or do you have plans to participate in skin or scuba diving; land or water vehicle competition or racing; sky diving, hang gliding or ballooning; rock or mountain climbing; or any other hazardous sports or activities? (If "Yes," complete Avocation Supplement.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Have you had life or disability insurance rejected or offered with an extra premium?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	In the past year, did you travel or reside outside the United States, or do you have plans to do so within the next two years? (If "Yes," state when, where, and how long.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Within the past 3 years, have you been convicted of, pleaded guilty or no contest to three or more moving violations and/or accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Within the past 5 years, have you been convicted of, pleaded guilty or no contest to, driving under the influence of alcohol and/or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i.	Has your driver's license ever been suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j.	Have you ever been convicted of, or pleaded guilty or no contest to, a Felony or Misdemeanor other than a minor traffic violation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k.	Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l.	Is the life insurance policy being applied for an "Employer-Owned Life insurance contract" under section 101(j)? (See Employer-Owned Life Insurance Information form at the end of this Application for more information.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m.	What is your height?	_____ ft. _____ in.		_____ ft. _____ in.	
n.	What is your weight?	_____ lbs.		_____ lbs.	

n. Details to "yes" answers:

10. NICOTINE USE — Complete for all Applications

Provide details below. Please attach additional sheet if more space is needed.		Proposed Insured 1		Proposed Insured 2	
		Yes	No	Yes	No
a.	Within the past 5 years, have you used any form of tobacco, nicotine or nicotine replacement therapy (for example — cigarette, cigar, pipe, chewing tobacco, nicotine gum, nicotine patch or nasal spray)?	Within 12 mos. <input type="checkbox"/>			
		Within 3 years <input type="checkbox"/>			
		Within 5 years <input type="checkbox"/>			
b.	If "Yes," list Type(s) and Amount used per day: Proposed Insured 1: Type(s) _____ Amount _____ Proposed Insured 2: Type(s) _____ Amount _____				

11. AUTHORIZATION TO OBTAIN, RELEASE, AND DISCLOSE INFORMATION

I, an undersigned Proposed Insured, authorize Hartford Life and Annuity Insurance Company (“The Hartford”) to complete a Personal History Interview and to obtain an Investigative Consumer Report on me (and on my minor children if they are applying for insurance). Further, I authorize the release of any medical or non-medical information that relates to me (and my minor children if they are applying for insurance) that is necessary for my application or determining eligibility for benefits, including (1) past or current health conditions including illnesses, sicknesses, diseases, disabilities, disorders, accidents, injuries, and drug prescriptions; (2) confinements in any hospital, medical facility, VA facility or medical clinic; (3) outpatient treatment in any hospital, hospital emergency room, medical facility, VA facility or medical clinic; and (4) treatment for alcohol abuse, drug abuse or mental health protected by Federal Law.

I authorize any person or organization that has records or knowledge of my health or driving record (and the health or driving record of my minor children, if they are applying for insurance) to release this information. This includes any doctor, medical professional, health practitioner, therapist, counselor, hospital, clinic or any other medically related facility, pharmacy benefit manager, VA facility or medical clinic, other insurance company, reinsurer, consumer reporting firm, employer, Motor Vehicle Division or the Medical Information Bureau (MIB). This information may be released for the purpose of determining eligibility for insurance under a new or an existing policy and/or eligibility for any benefits under the policy in the event of a claim. This information may be released to The Hartford or its legal representative. However, I understand that the MIB will release records of information only to The Hartford.

I understand that The Hartford may release this information in its file(s) to its reinsurer(s), the MIB, any other insurance company to which I or my minor children apply for life or health insurance, other persons and/or organizations performing business or legal services in connection with this application or a claim, or as required by law, including any mandated reporting to state agencies. I understand that if I request details about any of the medical information gathered about me or my minor children which relates to this application: (a) the medical information and (b) the identity of the medical care institution or the medical person who provided the information shall be released to me or to a licensed medical person of my choice. I also acknowledge receipt of The Hartford’s Notice of Information Practices.

I agree that a photocopy of this authorization is as valid as the original and understand that I may receive a copy of this authorization upon request. I also agree that this authorization shall be valid for twenty-four (24) months from the date shown below. This authorization may be revoked upon written request, except to the extent that action has already been taken. I understand that revocation may be a basis for denying insurance coverage and benefits.

12. DECLARATIONS AND SIGNATURES – Complete for all Applications

Each of the undersigned Proposed Insured(s) and Owner declare, understand and agree that:

1. All statements and answers contained in this application, together with any amendments and supplements, are complete and true to the best of our knowledge and belief.
2. The statements and answers set forth in this application and any amendments and supplements, are the basis for any insurance policy that may be issued. Owner, if not a Proposed Insured, adopts and ratifies such statements and answers.
3. A copy of the application and any amendments and supplements shall be attached to and be made a part of the policy, if issued.
4. The insurance policy applied for will take effect when the policy is delivered while the Insured(s) is/are living, all answers set forth in the application, together with any amendment and supplements, continue to be true and complete at the time of delivery and the first full modal premium is received prior to or upon delivery of the policy.
5. Only an officer of The Hartford can make, modify, alter or discharge the terms of the application amendments, supplements and policy, or waive any of The Hartford’s rights or requirements.
6. If any answers on this application, or any amendment or supplement, are incorrect or untrue, The Hartford will have the right to deny benefits or rescind the policy.
7. If the proposed policy is an “employer-owned life insurance contract” under IRC Section 101(j), in order for the death benefits to be fully federal income-tax free, a certification will be required at the time of a death claim that (1) the notice and consent requirements were fulfilled before the policy was issued, and (2) an exception under section 101(j)(2) applies. See the Employer-Owned Information Form at the end of this Application for more information.

Application Signed At _____ / _____ / _____
CITY STATE MONTH DAY YEAR

1. _____
Signature of Proposed Insured 1
(Parent or Guardian if under 15 years of age)

2. _____
Signature of Proposed Insured 2
(Parent or Guardian if under 15 years of age)

3. _____
Signature of Owner(s) if other than Proposed Insured(s)

➔ _____
Signature of Licensed Producer

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 04/01/2008

Comments:

Attachments:

AR Cert Rule 19.pdf
Readability Certification.pdf

Review Status:

Bypassed -Name: Application 04/01/2008

Bypass Reason: This submission is for an application only. The application is attached to the form schedule.

Comments:

Review Status:

Satisfied -Name: Fraud Notice FYI 04/10/2008

Comments:

Attachment:

Fraud Notice (07).pdf

Review Status:

Satisfied -Name: Statement of Variability 04/10/2008

Comments:

Attachment:

SOV.pdf

**ARKANSAS
POLICY FORM CERTIFICATION**

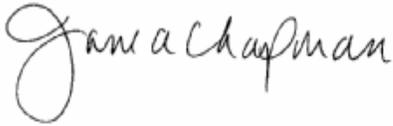
HARTFORD LIFE AND ANNUITY INSURANCE COMPANY

Form Number(s): LA-1253(08)

Form Title(s): Application for Life Insurance

By my signature below, I hereby certify that I have reviewed the enclosed policy form(s) and certify that the form(s) submitted meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.

Signed:

A handwritten signature in cursive script that reads "Jane A Chapman". The signature is written in black ink on a white background.

Jane A Chapman, AIRC, FLMI
Manager

Readability Certificate

I hereby certify that the forms referenced below have each been scored in their entirety using the Flesch Ease of Reading Test and have attained the score indicated. I further certify that, to the best of my knowledge and belief, said forms comply with state readability requirements and are printed in not less than ten point type, one point leaded.

The readability score was calculated by computer. The software used for this calculation was Microsoft Word.

Form Number
LA-1253(08)

Flesch Score
45.1

Hartford Life and Annuity Insurance Company
NAIC Number 71153-091



Signature of Insurance Company Officer

Lenore Paoli, AVP, Individual Life Business Practices
Typed Name and Title



NOTICE

THE LAWS OF THE FOLLOWING STATES REQUIRE THAT WE PROVIDE THESE NOTICES:

ARKANSAS:

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 is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KENTUCKY:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

LOUISIANA:

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 is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO:

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 is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA:

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 subjects such person to criminal and civil penalties.

TENNESSEE, VIRGINIA:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Hartford Life and Annuity Insurance Company

Statement of Variability

For

Application for Individual Flexible Premium Universal Life Insurance

LA-1253(08)

The section of the application which the applicant would complete for the coverage being applied for, i.e.: available products and optional riders, are shown as variable and denoted with brackets so that we may (a) remove products or optional riders that may no longer be offered by the company without re-filling; or (b) add new products or optional riders that would have been approved for use by the Department.