Filing at a Glance

Company: Hartford Life and Accident Insurance Company

Product Name: Application for Policy Change or Reinstatement for HLA	SERFF Tr Num: HARL-126602773	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 455603
Sub-TOI: L08.000 Life - Other	Co Tr Num: ILD-HL-19281(02/10) CW	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Roberta Chu, Barbara Warren, Frank Durante	Disposition Date: 05/11/2010
	Date Submitted: 05/06/2010	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:
State Filing Description:		

General Information

Project Name: Application for Policy Change or Reinstatement	Status of Filing in Domicile: Authorized
Project Number: HL-19281(02/10) CW	Date Approved in Domicile: 04/13/2010
Requested Filing Mode: Review & Approval	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: 05/11/2010	Explanation for Other Group Market Type:
	State Status Changed: 05/11/2010
Deemer Date:	Created By: Frank Durante
Submitted By: Roberta Chu	Corresponding Filing Tracking Number:

Filing Description:

We are submitting the subject form for your review and approval. The form is new and is not intended to replace any form previously approved by the Department.

Application for Policy Change and Reinstatement is intended for use with inforce individual variable and non-variable life insurance policies as approved or as may be approved by your Department. Policyowners will use this application to make policy changes, such as adding or deleting riders, increasing or decreasing face amounts, ior a change in death

benefit option. The application would be made a part of the Policy upon approval of and issuance of the changes applied form.

We have also enclosed for informational purposes the Fraud Notice which contains the required fraud statement and will always be used in conjunction with and made a part of the application.

Please note this identical form has been filed for Hartford Life Insurance Company and Hartford Life and Annuity Insurance Company this same day under separate SERFF submissions.

Text considered variable is denoted with brackets and described in the Statement of Variability. In addition, changes in printing technology may periodically alter slightly form format and we reserve the right to make such changes without refiling.

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

Frank Durante, Sr. Spec Business Compl
200 Hopmeadow St
Simsbury, CT 06089
frank.durante@hartfordlife.com
860-843-5858 [Phone]

Filing Company Information

Hartford Life and Accident Insurance Company	CoCode: 70815	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: 06-0838648	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*HARL-126602773*	*State:*	*Arkansas*
Filing Company:	*Hartford Life and Accident Insurance Company*	*State Tracking Number:*	*455603*
Company Tracking Number:	*ILD-HL-19281(02/10) CW*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Policy Change or Reinstatement for HLA*		
Project Name/Number:	*Application for Policy Change or Reinstatement/HL-19281(02/10) CW*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Hartford Life and Accident Insurance Company	$50.00	05/06/2010	36286430

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/11/2010	05/11/2010

Disposition

Disposition Date: 05/11/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HARL-126602773*	*State:*	*Arkansas*
Filing Company:	*Hartford Life and Accident Insurance Company*	*State Tracking Number:*	*455603*
Company Tracking Number:	*ILD-HL-19281(02/10) CW*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Policy Change or Reinstatement for HLA*		
Project Name/Number:	*Application for Policy Change or Reinstatement/HL-19281(02/10) CW*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Supporting Document	FYI - Fraud Notice		Yes
Form	Policy Change or Reinstatement Application		Yes

Form Schedule

Lead Form Number: HL-19281(02/10) CW

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	HL-19281(02/10) CW	Application/Enrollment Form	Policy Change or Reinstatement Application	Initial		50.100	HL-19281(02.10) CW Policy Change & Reinstate Application with brackets.pdf

Hartford Life Insurance Company ☐
Hartford Life and Annuity Insurance Company ☐
Hartford Life and Accident Insurance Company ☐
Hartford, CT 06104-2999
Individual Life Operations Address: **[**P.O. Box 64271 • St. Paul, Minnesota 55164-0271**]**

APPLICATION FOR POLICY CHANGE OR REINSTATEMENT

Questions? Call Individual Life Customer Service at 1-800-243-5433.

1. POLICY INFORMATION Complete this section for all applications.

a. Policy Number	b. Name of Insured
c. Is there a companion application for another insured? ❑ No ❑ Yes. Please provide details about that application, including the name of the proposed insured:	

2. TYPE OF REQUEST Select the appropriate option. For requests that require underwriting, complete all sections of this form. For requests that do not require underwriting, complete sections 1–3 and 12–14.

a. Requests that **Require** Underwriting	b. Requests that **Do Not Require** Underwriting
❑ Reinstate lapsed policy ❑ Increase face amount to: $_____ ❑ Add or increase the following riders or benefits: _____ _____	❑ Decrease face amount to: $_____ ❑ Remove or reduce the following riders or benefits: _____ _____
❑ Change death benefit option to: ❍ Level (Option A) ❍ Return of account value (Option B) ❍ Other: _____ ❑ Change risk information: ❍ Improve risk class ❍ Remove or reduce rating or Aviation Exclusion Rider	c. Other Requests; **May Require** Underwriting. Describe the request below: _____ _____ _____

3. PREMIUM INFORMATION Complete this section for all applications.

a. Premium Mode	b. Modal Premium (Amount per payment)	c. Total Annual Premium
❑ Monthly EFT* ❑ Semiannual bill ❑ Quarterly bill ❑ Annual bill ❑ Quarterly EFT* ❑ Non-billed * If this policy is not already set up for EFT payments, complete and submit an EFT request form. Quarterly EFT is not available for all policies.	$_____	$_____

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4. INSURED 1 INFORMATION

Complete this section only if underwriting is required (see Section 2). Provide this information for each existing and proposed insured.

a. Name of Insured (First, middle, and last)	b. Social Security Number

c. Date of Birth / /	d. State/Country of Birth	e. Gender ❑ Male ❑ Female

f. Residential Address. Please provide your permanent physical address; a P.O. box address is not acceptable.	g. Mailing Address (If different from residential address)

h. Daytime Phone ( )	i. Evening Phone ( )	j. Alternate Phone ( )

k. Preferred Phone Number to Call ❑ Daytime ❑ Alternate ❑ Evening	l. Preferred Time to Call ❑ am ❑ pm	m. Height ft. in.	n. Weight lb.

o. Driver's License, State ID, or Passport Number	p. State/Country of Issue	q. Expiration Date	r. Gross Annual Income $	s. Estimated Net Worth $

t. Employer	u. Occupation	v. Duties

5. ADDITIONAL INSUREDS

Complete this section only if underwriting is required (see Section 2). Provide this information for each existing and proposed insured. Each additional insured must make a separate copy of sections 7–10 and complete it.

a. Name of Insured 2 (First, middle, and last)	b. Social Security Number	c. Type of Coverage: ❑ Child Rider ❑ Additional Insured

d. Date of Birth / /	e. State/Country of Birth	f. Gender ❑ Male ❑ Female	g. Height ft. in.	h. Weight lb.

i. Driver's License, State ID, or Passport Number	j. State/Country of Issue	k. Expiration Date	l. Gross Annual Income $	m. Estimated Net Worth $

n. Employer	o. Occupation	p. Duties

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ADDITIONAL INSUREDS, CONTINUED

a. Name of Insured 3 (First, middle, and last)	b. Social Security Number	c. Type of Coverage: ❑ Child Rider ❑ Additional Insured

d. Date of Birth / /	e. State/Country of Birth	f. Gender ❑ Male ❑ Female	g. Height ft. in.	h. Weight lb.

i. Driver's License, State ID, or Passport Number	j. State/Country of Issue	k. Expiration Date	l. Gross Annual Income $	m. Estimated Net Worth $

n. Employer	o. Occupation	p. Duties

a. Name of Insured 4 (First, middle, and last)	b. Social Security Number	c. Type of Coverage: ❑ Child Rider ❑ Additional Insured

d. Date of Birth / /	e. State/Country of Birth	f. Gender ❑ Male ❑ Female	g. Height ft. in.	h. Weight lb.

i. Driver's License, State ID, or Passport Number	j. State/Country of Issue	k. Expiration Date	l. Gross Annual Income $	m. Estimated Net Worth $

n. Employer	o. Occupation	p. Duties

6. NICOTINE USE Complete this section only if underwriting is required (see Section 2). If you need more space, write the information in Section 11.

a. Within the past 5 years, have you used any form of tobacco, nicotine, or nicotine replacement therapy? Examples are cigarettes, cigars, pipe tobacco, chewing tobacco, Nicorette gum, nicotine patches, and nicotine nasal sprays.

	Insured 2 Name: _____	Insured 2 Name: _____	Insured 3 Name: _____	Insured 4 Name: _____
Within 12 months:	❑ Yes	❑ Yes	❑ Yes	❑ Yes
Within 3 years:	❑ Yes	❑ Yes	❑ Yes	❑ Yes
Within 5 years:	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

b. If you answered Yes, list the type(s) and amount used per day:

Insured 1: _____ Type: _____ Amount per day: _____

Insured 2: _____ Type: _____ Amount per day: _____

Insured 3: _____ Type: _____ Amount per day: _____

Insured 4: _____ Type: _____ Amount per day: _____

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7. GENERAL INFORMATION Complete this section only if underwriting is required (see Section 2). Complete a separate copy of this section for each existing and proposed insured. If you answer Yes to any questions, provide details in Section 11.

Name of Insured (First, middle, and last)

a. Are you a U.S. citizen? If not, what type of visa do you have? _____	❑ Yes ❑ No
b. Have you ever engaged in or do you plan to engage in any aviation activity other than as a fare-paying passenger? If you answer Yes, complete an Aviation Supplement.	❑ Yes ❑ No
c. In the past 2 years, did you participate in, or do you plan 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 you answer Yes, complete an Avocation Supplement.	❑ Yes ❑ No
d. Have you had insurance rejected, offered with an extra premium, or rated?	❑ Yes ❑ No
e. Do you plan to travel or reside outside the United States within the next 2 years? If you answer Yes, state when and for how long.	❑ Yes ❑ No
f. Has your driver's license ever been suspended or revoked?	❑ Yes ❑ No
g. Within the past 3 years, have you been convicted of or plead guilty or no contest to 3 or more moving violations and/or accidents?	❑ Yes ❑ No
h. Within the past 5 years, have you been convicted of or plead guilty or no contest to driving under the influence of alcohol and/or drugs?	❑ Yes ❑ No
i. Have you ever been convicted of or plead guilty or no contest to a felony or misdemeanor other than a minor traffic violation?	❑ Yes ❑ No
j. For questions g, h, and i above, do you currently have charges outstanding or violations pending? If you answer Yes, provide details.	❑ Yes ❑ No
k. Are you a member, or do you intend to become a member, of the armed forces, including the reserves?	❑ Yes ❑ No
l. Is all or any part of the future premium payments for this life insurance policy directly or indirectly being financed by an unrelated third party (individual or entity), or part of any loan arrangement? If you answer yes, provide details including the name of the program, vendor, and lender being used.	❑ Yes ❑ No
m. Is the life insurance policy being applied for an employer-owned life insurance contract under IRC Section 101(j)? (See the Employer-owned Life Insurance Information page at the end of this application for more information.)	❑ Yes ❑ No

n. Primary physician, health care provider, or clinic:
Name: _____ Date of Last Visit: _____/_____/_____
Address: _____

o. During the past 5 years, have you seen a physician or health care provider for any reason? If you answer Yes, provide information below for each visit in questions p, q, and r. If you need more space, write the information in Section 11.	❑ Yes ❑ No

p. Date of Visit: _____/_____/_____ Physician Name: _____
Reason for Visit: _____ Results: _____
Address: _____ Phone: (_____)_____

q. Date of Visit: _____/_____/_____ Physician Name: _____
Reason for Visit: _____ Results: _____
Address: _____ Phone: (_____)_____

r. Date of Visit: _____/_____/_____ Physician Name: _____
Reason for Visit: _____ Results: _____
Address: _____ Phone: (_____)_____

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8. MEDICAL QUESTIONS Complete this section only if underwriting is required (see Section 2). Complete a separate copy of this section for each existing and proposed insured. If you answer Yes to any questions, provide details in Section 11.

Name of Insured (First, middle, and last)

a.	Do you take any prescription medication, over-the-counter medication, or herbal remedy? If you answer Yes, provide the names and doses.	❑ Yes ❑ No
b.	Have you ever had, been treated for, or had treatment recommended by a member of the medical profession for:	
1.	High blood pressure; heart murmur or heart valve abnormality; chest pain; heart surgery: heart attack; abnormal heart rhythm; other heart or vascular disease, condition or disorder; stroke or mini-stroke (TIA)?	❑ Yes ❑ No
2.	Cancer; tumor or other abnormal growth; recurrent infections; lymph gland swelling or enlargement, immune system disease?	❑ Yes ❑ No
3.	Diabetes or other endocrine disease, condition or disorder (e.g. thyroid, adrenal, pituitary, etc.)?	❑ Yes ❑ No
4.	Anemia; blood transfusion; blood vessel disease; other blood disease, condition or disorder?	❑ Yes ❑ No
5.	Dizziness; fainting or loss of consciousness; Alzheimer's disease or dementia; epilepsy or seizure disorder; brain or spinal cord disorder; other nervous system disease; depression; anxiety; stress or panic attacks; or other psychological disease, condition or disorder?	❑ Yes ❑ No
6.	Asthma; chronic bronchitis or emphysema; other lung disease condition or disorder; sleep apnea or narcolepsy?	❑ Yes ❑ No
7.	Disease of the esophagus, pancreas or stomach; ulcerative colitis or Crohn's disease; chronic indigestion, diarrhea or vomiting; hepatitis or other disease of the liver; hernia, other gastrointestinal disease, condition or disorder?	❑ Yes ❑ No
8.	Bladder disease, kidney disease, prostate disease, sugar, protein or blood in the urine, breast disease, other genitourinary disease, condition or disorder?	❑ Yes ❑ No
9.	Rheumatoid arthritis, lupus, other connective tissue disease, condition or disorder, arthritis, rheumatism or other joint disease, condition or disorder; disease, condition or disorder of bones, back or spine; disease condition or disorder of muscles, ligaments or tendons?	❑ Yes ❑ No
10.	Ear disease or eye disease, condition or disorder?	❑ Yes ❑ No
11.	Chronic fatigue, fibromyalgia or myalgia?	❑ Yes ❑ No
c.	To the best of your knowledge and belief, have you ever been diagnosed or treated by a member of the medical profession as having acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or AIDs-related conditions?	❑ Yes ❑ No
d.	Have you had a consultation, treatment or examination by a physician, health care provider or clinic for any reason not listed above?	❑ Yes ❑ No
e.	Do you have any reason to believe that you are not currently in good health? Good health is defined as a state in which there is no current or pending need for the services of a member of the medical profession for reasons other than for conditions such as a common cold or an annual physical exam.	❑ Yes ❑ No
f.	Do you engage in regular exercise? If you answer Yes, provide details.	❑ Yes ❑ No
g.	Have you lost 10 or more pounds in the last 6 months (unrelated to a change in diet)?	❑ Yes ❑ No

h.	In the past 5 years, have you used any illicit drug or prescription drug that was not prescribed by a physician? If you answer Yes, provide details including any treatment recommended or given.	❑ Yes ❑ No
i.	Do you currently consume alcoholic beverages? If you answer Yes, describe how many per day and per week.	❑ Yes ❑ No
j.	Have you ever been treated or counseled, or had treatment recommended that was not completed, for alcohol or drug abuse?	❑ Yes ❑ No
k.	Females only: Are you currently pregnant? If you answer yes, what is your due date?	❑ Yes ❑ No
l.	Have you lost more than 5 consecutive days of work due to any health condition in the last 3 years?	❑ Yes ❑ No

9. AGE 70 AND OLDER Complete this section only if underwriting is required (see Section 2). Complete a separate copy of this section for each existing and proposed insured who is age 70 or older. If you answer Yes to any questions, provide details in Section 11.

Name of Insured (First, middle, and last)

a.	Has any insured undergone or is any insured considering to undergo any life expectancy evaluation and/or calculation, or has any individual or entity (other than The Hartford) performed an analysis of the Insured's expected mortality in connection with this application for policy change or reinstatement?	❑ Yes ❑ No
b.	Has the policyowner or any insured been offered or promised any incentive (financial or otherwise) as an inducement to change or reinstate the policy such as (but not limited to) zero-cost or no-cost life insurance or other cash payments?	❑ Yes ❑ No
c.	Has the policyowner or any insured had any discussions about establishing an ownership or beneficiary designation, either now or in the future, which would provide beneficial interest from this policy to individuals or entities that do not have an insurable interest in the life of the insured? (This includes, but is not limited to, any discussions regarding a change in beneficial interest within a trust.) Insurable interest requires individuals to be related by blood or marriage, hold a substantial interest engendered by love and affection, have a legal and substantial economic interest in the continued life of the insured, or have a business relationship that is not enhanced in value by the death of the insured.	❑ Yes ❑ No
d.	Is the policyowner or any insured considering assigning or transferring rights or interest in this policy to an unrelated third party such as (but not limited to) a collateral assignment, life settlement, viatical, bank, and/or lending or investment company?	❑ Yes ❑ No
e.	Has the policyowner or any insured had any discussions or consider entering into any arrangement that requires or allows the policyowner to relinquish ownership (either now or in the future) in the ownership arrangement of the policy or, if ownership of the policy will be a trust, amend the trust arrangement after the policy is issued?	❑ Yes ❑ No
f.	Is the policy being changed or reinstated at the request of or for the benefit of an investor, stranger or unrelated third party?	❑ Yes ❑ No

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10. LIFE INSURANCE IN FORCE AND PENDING

Complete this section only if underwriting is required (see Section 2). Complete a separate copy of this section for each existing and proposed insured. If you answer Yes to any questions, provide details in Section 10d and 10e. If you need more space, use Section 11.

Name of Insured (First, middle, and last)

a. Do any of the insureds have existing life insurance and/or annuities in force on his or her life? This includes any policies that may have been transferred, assigned or sold to a third party. If you answer Yes, provide information about the company and policy in the spaces below.	❑ Yes ❑ No
b. Do any of the insureds have any life insurance applications or inquiries pending with any other carrier? This includes applications or inquiries that are bound by a temporary insurance agreement or conditional receipt. If you answer Yes, provide information about the company and policy in the spaces below.	❑ Yes ❑ No
c. Is the insurance under this application intended to replace or change any existing life insurance or annuity contract (including any applications bound by a temporary insurance agreement or conditional receipt) that the insured(s) may have with The Hartford or any other carrier? If you answer Yes, provide information about the company and policy in the spaces below.	❑ Yes ❑ No

d. Company: _____ Policy Number: _____
Insured Name: _____ Amount: $_____ Year Issued: _____
To Be Replaced? ❑ Yes ❑ No Type of Insurance: ❑ Individual ❑ Business ❑ Group

e. Company: _____ Policy Number: _____
Insured Name: _____ Amount: $_____ Year Issued: _____
To Be Replaced? ❑ Yes ❑ No Type of Insurance: ❑ Individual ❑ Business ❑ Group

11. ADDITIONAL INFORMATION

Complete this section only if underwriting is required (see Section 2). Use this section to provide details for any Yes answers in Sections 6–10.

Insured Name	Section	Question	Details

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12. PRODUCER INFORMATION Complete this section for all applications. To be completed by the producer.

a. Producer Name	b. Producer Phone Number	c. Producer Fax Number
	( )	( )

d. Producer Code	e. Producer Email Address

f. Do you have any knowledge or reason to believe that the Proposed Policyowner or Insured(s) are considering assigning or transferring rights or interest in this policy now or in the future, including ownership or beneficiary interests, to an unrelated party such as (but not limited to) a life settlement, viatical, bank and/or lending or investment company? (If "Yes," provide details.)	❑ Yes ❑ No
g. Do you have any knowledge or reason to believe that any discussions have occurred with the Proposed Owner, Proposed Insured, or any other individuals involved in the solicitation of the policy about establishing an ownership or beneficiary designation, either now or in the future, which would provide beneficial interest to individuals or entities that do not have an insurable interest in the life of the Proposed Insured(s)? (This would include, but not limited to, any discussions regarding a change in beneficial interest within a trust.) (If "Yes," provide details.)	❑ Yes ❑ No
h. Do you have any knowledge or reason to believe that the proposed Policyowner or Insured(s) has been offered any financial incentives as inducements to apply for this policy such as (but not limited to) premium loans or other payments equal to or in excess of the premium? (If "Yes," provide details.)	❑ Yes ❑ No
i. Do you have any knowledge or reason to believe that any of the Proposed Insureds have undergone or are considering to undergo any life expectancy evaluation and/or calculation as well as any analysis of the Insured's expected mortality from an individual or entity other than The Hartford in connection with the application for this policy?	❑ Yes ❑ No
j. Do you have knowledge or reason to believe that replacement of existing life insurance or annuities is involved in this transaction?	❑ Yes ❑ No
k. Do you have any knowledge or reason to believe that this life insurance policy is or will be replacing all or any part of a policy that has been, or is in the process of being sold to an unrelated third party such as (including but not limited to) a life settlement, viatical, bank and/or lending or investment company? (If "Yes," provide details.)	❑ Yes ❑ No

l. If replacing, state the total amount of existing life insurance that will remain in force: $_____

m. Have any medical requirements been ordered?

❑ No

❑ Yes. Please describe the type and date ordered:

_____

_____

_____

_____

_____

_____

13. AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

I, an undersigned Insured, authorize Hartford Life Insurance Company, Hartford Life and Annuity Insurance Company, or Hartford Life and Accident 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 The Hartford to underwrite my application, to service the policy that may be issued in connection with the application or to determine my eligibility and/or Hartford's obligations under the policy. The medical and/or non-medical information shall include, but not be limited to: (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; (4) treatment for alcohol abuse, drug abuse or mental health protected by Federal Law; (5) other life insurance policies or coverage's which may be currently applied for or in force on my life or the lives of my minor children; (6) motor vehicle violations; and (7) financial information.

I authorize any person or organization that has such medical or non-medical information 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, any company that evaluates a person's expected mortality or life expectancy, life settlement company, consumer reporting firm, employer, accountant, motor vehicle division or the Medical Information Bureau (MIB, Inc.). This information may be released to The Hartford or its legal representative. However, I understand that the MIB, Inc. will release records of information only to The Hartford.

I understand that The Hartford may disclose the information in its file(s) to its reinsurer(s), the MIB, Inc., other insurance companies, other persons and/or organizations performing business functions on behalf of The Hartford, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me or my minor children which relates to this application and that such requested information and the identity of the source of the information shall be released to me or in the case of medical information, to a licensed medical person of my choice.

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 thirty (30) months from the date shown below. This authorization may be revoked upon written request, except to the extent that action has already been taken. However, I understand that revocation may be a basis for denying my insurance application and/or coverage and benefits. I also acknowledge receipt of The Hartford's Notice of Information Practices.

14. DECLARATIONS AND SIGNATURES

Complete this section for all requests. If your request requires underwriting, all insureds must sign.

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

a. 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.

b. 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. The Policyowner, if not an Insured, adopts and ratifies such statements and answers.

c. A copy of the application and any amendments and supplements shall be attached to and be made a part of the policy, if issued.

d. The insurance policy applied for will take effect only if the Insured(s) are living; any amendments to the application are properly signed; all answers set forth in the application, together with any amendments and supplements, continue to be true and complete at the time the policy is delivered; and the first full modal premium is received.

e. 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.

f. 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.

g. If the 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.

h. The Proposed Insured(s) have read and understood the Authorization to Obtain, Release and Disclose Information.

This application was signed at _____, _____ on _____/_____/_____.
City State MM DD YYYY

_____
Signature of Insured 1
(Parent or guardian if under 15 years of age)

_____
Signature of Insured 2
(Parent or guardian if under 15 years of age)

_____
Signature of Insured 3
(Parent or guardian if under 15 years of age)

_____
Signature of Insured 4
(Parent or guardian if under 15 years of age)

_____
Signature of Policyowner (If other than the Insured)

_____
Signature of Irrevocable Beneficiary

_____
Signature of Licensed Insurance Producer

Hartford Life Insurance Company
Hartford Life and Annuity Insurance Company
Hartford Life and Accident Insurance Company
Hartford, CT 06104-2999
Individual Life Operations Address: [P.O. Box 64271 • St. Paul, Minnesota 55164-0271]

Producer: You must remove this notice and leave it with the Insured(s).

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, Inc.) PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. Hartford Life Insurance Company, Hartford Life and Annuity Insurance Company, or Hartford Life and Accident Insurance Company ("The Hartford") or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau (MIB, Inc.), 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, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc. upon request will supply such a company with the information in its file. Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The web address of the MIB, Inc. information office is www.MIB.com. You can also reach MIB, Inc. at 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or 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.

The Hartford 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: The Hartford, 500 Bielenberg Drive, Woodbury, Minnesota 55125.

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

Readability Certification for HLA.pdf

AR Certification - Rule 19 for HLA.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: n/a - this is an application submission.

Comments:

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachment:

AR Certification - Rule 19 for HLA.pdf

Item Status: **Status Date:**

Satisfied - Item: FYI - Fraud Notice

Comments:

Attachment:

HL-15883_10_ FRAUD STATEMENT NOTICE.pdf

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	Flesch Score
HL-19281(02/10) CW	50.1

Hartford Life and Accident Insurance Company
NAIC Number 70815-091

Signature of Insurance Company Officer

Lenore Paoli, AVP, ILD Business Practices and Compliance
Typed Name and Title

ARKANSAS
POLICY FORM CERTIFICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Form Number(s): HL-19281(02/10) CW
Form Title(s): Application for Policy Change or Reinstatement

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 entitled "Unfair Discrimination in Sale of Insurance" as well as all applicable requirements of the Arkansas Insurance Department.

Signed:

_____ 05/06/2010
Date
Lenore Paoli, AVP, Business Practices and Compliance

ARKANSAS
POLICY FORM CERTIFICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Form Number(s): HL-19281(02/10) CW
Form Title(s): Application for Policy Change or Reinstatement

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 entitled "Unfair Discrimination in Sale of Insurance" as well as all applicable requirements of the Arkansas Insurance Department.

Signed:

_____ 05/06/2010
Date
Lenore Paoli, AVP, Business Practices and Compliance

FRAUD STATEMENT NOTICE

THE LAWS OF THE FOLLOWING STATES REQUIRE THAT WE PROVIDE THIS FRAUD STATEMENT NOTICE TO YOU WITH YOUR APPLICATION:

ARKANSAS, LOUISIANA, RHODE ISLAND:
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 mis-leading 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 de-fraud 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.

MARYLAND:
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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.