

SERFF Tracking Number: HARL-126610487 State: Arkansas  
 Filing Company: Hartford Life and Annuity Insurance Company State Tracking Number: 45571  
 Company Tracking Number: HL-19287(10)  
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life  
 Adjustable Life  
 Product Name: Binding Receipt and Amendment  
 Project Name/Number: Binding Receipt and Amendment/HL-19287(10)

## Filing at a Glance

Company: Hartford Life and Annuity Insurance Company

Product Name: Binding Receipt and Amendment SERFF Tr Num: HARL-126610487 State: Arkansas

TOI: L09I Individual Life - Flexible Premium SERFF Status: Closed-Approved- State Tr Num: 45571  
 Adjustable Life Closed

Sub-TOI: L09I.001 Single Life Co Tr Num: HL-19287(10) State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Linda Bird

Authors: Jane Chapman, Roberta Disposition Date: 05/05/2010

Chu, Barbara Warren, Frank

Durante

Date Submitted: 05/03/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Binding Receipt and Amendment

Status of Filing in Domicile: Not Filed

Project Number: HL-19287(10)

Date Approved in Domicile:

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: 05/05/2010

Explanation for Other Group Market Type:

State Status Changed: 05/05/2010

Deemer Date:

Created By: Barbara Warren

Submitted By: Barbara Warren

Corresponding Filing Tracking Number:

Filing Description:

We are submitting the subject forms for your review and approval. The forms are new and not intended to replace any forms previously approved by the Department. Both forms have been designed to be used in a new policy issue program which is intended to accelerate the issuance of applied-for Individual Flexible Premium Universal Life Insurance Policies approved or as may be approved by the department. At this time, it is not intended to be used with our Variable or Term Life product portfolio.

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Under the program, applicants will complete the Binding Premium Receipt HL-19287(10) and, if all of the answers to the health questions in the receipt are answered “no” and we receive the modal premium, temporary life insurance goes into effect on the date the applicant signs the receipt. Eligibility for this receipt is described in the form as well as Limitations and Conditions of Coverage and other important information and disclosures.

Once we receive the Receipt, the first full model premium, a completed application, and other required documents (e.g. Life Illustration), we will deliver the Policy (including the completed Application and other documents required at policy delivery) within 48 hours and prior to completing our underwriting review. Death Benefit coverage under the Policy, as well as policy charges and cost of insurance rates, will be based on the insurance class as illustrated at the time of application for the Policy. Form LA-1341(10), which is an Amendment, will be attached to and delivered with the Policy. The Amendment explains that Our underwriting review of the Insured has not yet been completed by Us and any optional Riders applied for on the Application for Life Insurance (“Application”) have not yet been issued by Us.

The date the Policy takes effect, coverage under the Binding Receipt terminates. If the Insured dies during our underwriting review, all of the provisions of the Policy as issued will apply, including payment of the death proceeds.

During our underwriting review, we may rescind the Policy based only on our review of non-medical evidence of insurability provided to Us in the Application or as part of Our underwriting process, such as misrepresentation in the Receipt or lack of insurable interest.

Upon completion of Our underwriting review, We will issue an Endorsement to the Policy as well as revised Policy Specification Pages reflecting the Insured’s final Insurance Class (either as illustrated or as may be otherwise determined based on our underwriting review). The Endorsement and revised specification pages will reflect any other changes to the Policy that are required based on our final underwriting, such as Cost of Insurance and other Policy charges, Initial Face Amount, or Death Benefit Option changes. We will also issue at this time any Riders for other benefits applied for on the Application and approved by Us. In addition, the Amendment revises the Free Look period of the Policy so that it extends from the date the final Policy Endorsement described above is received (versus from the date the Policy is received) to give Policy Owners ample opportunity to reject the Policy upon receipt of the Policy Endorsement reflecting our final underwriting determination.

Variability is denoted with brackets and explained in the statement of variability accompanying this submission.

We are also providing any certifications or other documentation that may be required by your state. Your review and approval of this submission is greatly appreciated. Please feel free to contact me with any questions you may have.

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## 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

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: 50.00 per form x 2 forms = 100.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Hartford Life and Annuity Insurance Company	\$100.00	05/03/2010	36174405

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## Correspondence Summary

### Dispositions

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

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Binding Receipt	Barbara Warren	05/04/2010	05/04/2010

*SERFF Tracking Number:*     *HARL-126610487*                     *State:*                     *Arkansas*  
*Filing Company:*             *Hartford Life and Annuity Insurance Company*     *State Tracking Number:*     *45571*  
*Company Tracking Number:*     *HL-19287(10)*  
*TOI:*                     *L09I Individual Life - Flexible Premium*     *Sub-TOI:*                     *L09I.001 Single Life*  
                                   *Adjustable Life*  
*Product Name:*             *Binding Receipt and Amendment*  
*Project Name/Number:*         *Binding Receipt and Amendment/HL-19287(10)*

## **Disposition**

Disposition Date: 05/05/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	HL-19287(10) Binding Receipt & Amendment SOV		Yes
Form (revised)	Binding Receipt		Yes
Form	Binding Receipt	Replaced	Yes
Form	Amendment		Yes

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**Amendment Letter**

Submitted Date: 05/04/2010

**Comments:**

We have amended the filing to replace the form originally submitted with the newly attached form.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
HL-19287(10)	Application/EBinding nrollment Form	Receipt	Initial				50.600	HL-19287(10).pdf

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## Form Schedule

**Lead Form Number: HL-19287(10)**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	HL-19287(10)	Application/Binding Receipt Enrollment Form	Initial		50.600	HL-19287(10).pdf
	LA-1341(10)	Policy/Cont Amendment ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		45.400	LA-1341(10).pdf



Hartford Life and Annuity Insurance Company  
[P.O. Box 64271, St. Paul, Minnesota 55164-0271]

## BINDING PREMIUM RECEIPT

### Definitions

The definitions in this section apply to the following words and phrases whenever and wherever they appear in this Receipt.

**Application:** means an Application for Life Insurance.

**Request:** means a Request for Insurance Application.

**Primary Insured:** means "Proposed Insured 1" named in the Application or Request, or "Proposed Insured 1" and "Proposed Insured 2" named in the Application or Request for a survivorship policy.

**We, Our, Us:** means the Hartford Life and Annuity Insurance Company

**You, Your:** means the individual applying for the life insurance policy.

### Description Of Coverage

Provided you meet all of the Eligibility Requirements described below, We agree to provide coverage under this Receipt for the Primary Insured(s) effective on the date it is signed by You.

### Eligibility Requirements

Coverage under this Receipt becomes effective on the date this Receipt is signed by You, subject to **all** of the following conditions:

1. **all answers to the Health Questions below are answered NO;**
2. the face amount of the applied for policy is less than [\$1,000,000];
3. An Application or Request has been completed as of the same date this Receipt is signed;
4. the applied for policy is not an "employer-owned life insurance contract under Internal Revenue Code Section 101(j); and
5. We receive no less than the first full modal premium for the mode selected on the Application or Request.

### Amount Of Life Insurance Coverage Under This Receipt

If death of a covered Primary Insured occurs while this Receipt is in effect, We will pay the death benefit to the beneficiary designated in the Application or Request.

### Limitations And Conditions Of Coverage Under This Receipt

1. This Receipt provides coverage only for the Primary Insured(s). **This Receipt does not provide coverage for any other proposed insureds, including, but not limited to, other proposed insureds under term insurance riders and child riders;**
2. This Receipt does not provide coverage if the Primary Insured(s) is age [66] or older on his/her birthday nearest the date this Receipt is signed;
3. This Receipt provides coverage in the event of death of the Primary Insured(s). It does not provide any coverage for **other benefits which may be applied for**, including but not limited to, accelerated death benefits, disability income benefits, or accidental death benefits;
4. There is no coverage under this Receipt if a Primary Insured dies by suicide. In this event, Our liability will be limited to a refund of the total premium paid for the Policy; and
5. **Material misrepresentations or fraud in the answers to the Health Questions set forth below or in the Application, will invalidate this Receipt and may be the basis for denial of benefits under, or rescission of, the applied for Policy.** In this event, Our liability will be limited to a refund of the total premium paid for the Policy.

**If benefits are payable under this Receipt, then no benefit relating to that loss will be payable under the applied for Policy**

HL-19287(10)

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HOME OFFICE COPY

1 of 3

You have applied for a life insurance policy with Us. If the answers to the health questions below are “no” and You provide Us with no less than the first full modal premium for the mode selected on the Application or Request, the death benefit applied for shall take effect under this Receipt in the event of death of a covered Primary Insured as a result of accidental or natural causes originating after the date this Receipt and the Application or Request is signed.

**IF ANY QUESTION BELOW IS ANSWERED “YES” OR LEFT BLANK, NO COVERAGE WILL TAKE EFFECT UNDER THIS RECEIPT AND THE TOTAL PREMIUM PAID FOR THE POLICY WILL BE REFUNDED.**

**The answers below apply to the Proposed Primary Insured. In the event a survivorship policy is applied for, “Primary Insured” means “Proposed Insured 1” and “Proposed Insured 2” named in the Application or Request.**

**Has the Primary Insured(s):**

1.  Yes  No ever had insurance rejected or offered with an extra premium or rating?
2.  Yes  No in the last 5 years:
  - been treated or had treatment recommended for alcohol or drug abuse;
  - been convicted of driving under the influence of alcohol and/or drugs; or
  - used any illegal drug or prescription drug that was not prescribed for you by a health care provider or used a drug prescribed to you other than as prescribed?
3.  Yes  No ever had, been treated for or had treatment recommended by a health care provider for:
  - Immune System Disease;
  - Human Immunodeficiency Virus (HIV) Infection; or
  - Acquired Immune Deficiency Syndrome (AIDS)?
4.  Yes  No ever had or been treated for, or ever been (or currently being) evaluated for or advised to seek an evaluation for:
  - Cancer
  - Kidney failure
  - Organ transplant
  - Cardiac arrest
  - Heart surgery
  - An implanted defibrillator
  - Hepatitis C
  - Progressive muscular or neurologic disease
  - Alzheimer’s disease or dementia
  - Stroke
  - Cardiomyopathy or congestive heart failure, or
  - Any lung or breathing disorder requiring oxygen
5.  Yes  No within the last 6 months, other than for pregnancy or childbirth:
  - been admitted to or treated at a hospital or other medical facility (except for routine office visits to a health care provider);
  - been advised to be admitted to or treated at a hospital or other medical facility;
  - had surgery performed or recommended;
  - had an unintentional loss of 10 pounds or more of his/her body weight; or
  - Undergone any medical testing (excluding HIV testing) or medical evaluation by a health care provider or had testing recommended for which a final diagnosis has not been determined (excluding HIV testing)?
6.  Yes  No ever been convicted of, pleaded guilty or no contest to any felony violation?

**When The Binding Premium Receipt Terminates**

Coverage under this Receipt will terminate on the earliest of the following to occur:

1. the date the policy takes effect, in which case Your initial premium payment will be applied to the policy as of the policy’s effective date;
2. the date of death of the covered Primary Insured, in which case We will pay the death benefit to the beneficiary designated in the Application or Request;
3. the date We mail a notice of termination of this Receipt to the Proposed Policyowner at the address set forth in the Application or Request; and
4. the date We receive Your written request to terminate coverage under this Receipt.

In the case of 3. and 4. above, Our liability will be limited to a refund of the total premium paid for the policy.

No agent or other company representative may waive or modify the answer to any question in the Application or Request or modify the terms or conditions of this Receipt.

**DECLARATIONS AND SIGNATURES**

Each of the undersigned declares, understands and agrees that:

- The answers provided above are complete and true to the best of his/her knowledge and belief.
- The statements and answers set forth in this Receipt are made a part of the Application for Life Insurance and are the basis for any insurance policy that may be issued. Owner, if not a Proposed Primary Insured, adopts and ratifies such statements and answers.
- If the answers to the Health Questions contained in this Receipt or Application are incorrect, incomplete or untrue, the Company will have the right to deny benefits under this Receipt, or deny benefits under, or rescind, the applied for policy.
- A copy of this Receipt shall be attached to and made a part of the policy, if issued.

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Proposed Primary Insured 1**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Proposed Primary Insured 2**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Proposed Policy Owner (if other than the Proposed Insured(s))**

**RECEIPT OF PAYMENT**

A premium payment of \$ \_\_\_\_\_ has been submitted with the Application or Request. Any check or draft is received subject to collection, and, if it is not honored when presented for payment, this receipt is void.

**All premium checks must be made payable to Hartford Life and Annuity Insurance Company. Do not make check(s) payable to the Agent or leave the payee blank.**

X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Licensed Insurance Producer

DETACH OWNER'S COPY AT TIME OF APPLICATION



Hartford Life and Annuity Insurance Company  
[P.O. Box 64271, St. Paul, Minnesota 55164-0271]

## BINDING PREMIUM RECEIPT

### Definitions

The definitions in this section apply to the following words and phrases whenever and wherever they appear in this Receipt.

**Application:** means an Application for Life Insurance.

**Request:** means a Request for Insurance Application.

**Primary Insured:** means "Proposed Insured 1" named in the Application or Request, or "Proposed Insured 1" and "Proposed Insured 2" named in the Application or Request for a survivorship policy.

**We, Our, Us:** means the Hartford Life and Annuity Insurance Company

**You, Your:** means the individual applying for the life insurance policy.

### Description Of Coverage

Provided you meet all of the Eligibility Requirements described below, We agree to provide coverage under this Receipt for the Primary Insured(s) effective on the date it is signed by You.

### Eligibility Requirements

Coverage under this Receipt becomes effective on the date this Receipt is signed by You, subject to **all** of the following conditions:

1. **all answers to the Health Questions below are answered NO;**
2. the face amount of the applied for policy is less than [\$1,000,000];
3. An Application or Request has been completed as of the same date this Receipt is signed;
4. the applied for policy is not an "employer-owned life insurance contract under Internal Revenue Code Section 101(j); and
5. We receive no less than the first full modal premium for the mode selected on the Application or Request.

### Amount Of Life Insurance Coverage Under This Receipt

If death of a covered Primary Insured occurs while this Receipt is in effect, We will pay the death benefit to the beneficiary designated in the Application or Request.

### Limitations And Conditions Of Coverage Under This Receipt

1. This Receipt provides coverage only for the Primary Insured(s). **This Receipt does not provide coverage for any other proposed insureds, including, but not limited to, other proposed insureds under term insurance riders and child riders;**
2. This Receipt does not provide coverage if the Primary Insured(s) is age [66] or older on his/her birthday nearest the date this Receipt is signed;
3. This Receipt provides coverage in the event of death of the Primary Insured(s). It does not provide any coverage for **other benefits which may be applied for**, including but not limited to, accelerated death benefits, disability income benefits, or accidental death benefits;
4. There is no coverage under this Receipt if a Primary Insured dies by suicide. In this event, Our liability will be limited to a refund of the total premium paid for the Policy; and
5. **Material misrepresentations or fraud in the answers to the Health Questions set forth below or in the Application, will invalidate this Receipt and may be the basis for denial of benefits under, or rescission of, the applied for Policy.** In this event, Our liability will be limited to a refund of the total premium paid for the Policy.

**If benefits are payable under this Receipt, then no benefit relating to that loss will be payable under the applied for Policy.**

HL-19287(10)

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You have applied for a life insurance policy with Us. If the answers to the health questions below are “no” and You provide Us with no less than the first full modal premium for the mode selected on the Application or Request, the death benefit applied for shall take effect under this Receipt in the event of death of a covered Primary Insured as a result of accidental or natural causes originating after the date this Receipt and the Application or Request is signed.

**IF ANY QUESTION BELOW IS ANSWERED “YES” OR LEFT BLANK, NO COVERAGE WILL TAKE EFFECT UNDER THIS RECEIPT AND THE TOTAL PREMIUM PAID FOR THE POLICY WILL BE REFUNDED.**

**The answers below apply to the Proposed Primary Insured. In the event a survivorship policy is applied for, “Primary Insured” means “Proposed Insured 1” and “Proposed Insured 2” named in the Application or Request.**

**Has the Primary Insured(s):**

1.  Yes  No ever had insurance rejected or offered with an extra premium or rating?
2.  Yes  No in the last 5 years:
  - been treated or had treatment recommended for alcohol or drug abuse;
  - been convicted of driving under the influence of alcohol and/or drugs; or
  - used any illegal drug or prescription drug that was not prescribed for you by a health care provider or used a drug prescribed to you other than as prescribed?
3.  Yes  No ever had, been treated for or had treatment recommended by a health care provider for:
  - Immune System Disease;
  - Human Immunodeficiency Virus (HIV) Infection; or
  - Acquired Immune Deficiency Syndrome (AIDS)?
4.  Yes  No ever had or been treated for, or ever been (or currently being) evaluated for or advised to seek an evaluation for:
  - Cancer
  - Kidney failure
  - Organ transplant
  - Cardiac arrest
  - Heart surgery
  - An implanted defibrillator
  - Hepatitis C
  - Progressive muscular or neurologic disease
  - Alzheimer’s disease or dementia
  - Stroke
  - Cardiomyopathy or congestive heart failure, or
  - Any lung or breathing disorder requiring oxygen
5.  Yes  No within the last 6 months, other than for pregnancy or childbirth:
  - been admitted to or treated at a hospital or other medical facility (except for routine office visits to a health care provider);
  - been advised to be admitted to or treated at a hospital or other medical facility;
  - had surgery performed or recommended;
  - had an unintentional loss of 10 pounds or more of his/her body weight; or
  - Undergone any medical testing (excluding HIV testing) or medical evaluation by a health care provider or had testing recommended for which a final diagnosis has not been determined (excluding HIV testing)?
6.  Yes  No ever been convicted of, pleaded guilty or no contest to any felony violation?

**When The Binding Premium Receipt Terminates**

Coverage under this Receipt will terminate on the earliest of the following to occur:

1. the date the policy takes effect, in which case Your initial premium payment will be applied to the policy as of the policy’s effective date;
2. the date of death of the covered Primary Insured, in which case We will pay the death benefit to the beneficiary designated in the Application or Request;
3. the date We mail a notice of termination of this Receipt to the Proposed Policyowner at the address set forth in the Application or Request; and
4. the date We receive Your written request to terminate coverage under this Receipt.

In the case of 3. and 4. above, Our liability will be limited to a refund of the total premium paid for the policy.

No agent or other company representative may waive or modify the answer to any question in the Application or Request or modify the terms or conditions of this Receipt.

**DECLARATIONS AND SIGNATURES**

Each of the undersigned declares, understands and agrees that:

- The answers provided above are complete and true to the best of his/her knowledge and belief.
- The statements and answers set forth in this Receipt are made a part of the Application for Life Insurance and are the basis for any insurance policy that may be issued. Owner, if not a Proposed Primary Insured, adopts and ratifies such statements and answers.
- If the answers to the Health Questions contained in this Receipt or Application are incorrect, incomplete or untrue, the Company will have the right to deny benefits under this Receipt, or deny benefits under, or rescind, the applied for policy.
- A copy of this Receipt shall be attached to and made a part of the policy, if issued.

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Proposed Primary Insured 1**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Proposed Primary Insured 2**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Proposed Policy Owner (if other than the Proposed Insured(s))**

**RECEIPT OF PAYMENT**

A premium payment of \$ \_\_\_\_\_ has been submitted with the Application or Request. Any check or draft is received subject to collection, and, if it is not honored when presented for payment, this receipt is void.

**All premium checks must be made payable to Hartford Life and Annuity Insurance Company. Do not make check(s) payable to the Agent or leave the payee blank.**

X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Licensed Insurance Producer

DETACH OWNER'S COPY AT TIME OF APPLICATION



## AMENDMENT

### GENERAL

As of the Date of Issue of this Policy, Our underwriting review of the Insured has not yet been completed by Us and any Riders applied for on the Application for Life Insurance (“Application”) have not yet been issued by Us. “Insured” means both Insureds named in the Application for a last survivorship policy.

Our underwriting review and our Final Underwriting Determination will be performed by Us in good faith and in a non-discriminatory manner using Our underwriting guidelines and insurability rules.

During Our underwriting review, We may rescind the Policy. Such rescission will be based on Our review of any non-medical evidence of insurability as provided to Us in the Application, or other requested non-medical insurability requirements provided to Us as part of Our underwriting process. If this occurs, coverage under the Policy will no longer be in force and the Policy will terminate as described under the Policy Termination provision of this Amendment. In this event, Our liability will be limited to a refund of the total premiums paid for the Policy.

### FINAL UNDERWRITING DETERMINATION

Upon completion of Our underwriting review, if We have not terminated Your Policy, We will issue a Policy Endorsement reflecting the Insured’s final Insurance Class. The Policy Endorsement will reflect any other changes to the Policy that are required based on our Final Underwriting Determination, including but not limited to, Cost of Insurance and other Policy charges, Initial Face Amount, Death Benefit Option, and any No Lapse Guarantee Premium. The Policy Endorsement will also include any other changes in coverage from that applied for on the Application as requested by You, such as changes in Planned Premium, Initial Face Amount, or Death Benefit Option. We will also issue at this time any Riders for other benefits applied for on the Application and approved by Us. Additional premium may be required upon delivery of the Policy Endorsement.

### OTHER POLICY TRANSACTIONS

Policy Loans or any option to continue the Policy as reduced paid up will not be available during Our underwriting review until the date a Policy Endorsement as described above is received by You.

## THE FOLLOWING PROVISIONS OF THE POLICY ARE AMENDED AS FOLLOWS:

### RIGHT TO EXAMINE

**We want You to be satisfied with the Policy You have purchased. We urge You to examine it closely. If, for any reason You are not satisfied, You may deliver or mail the Policy to Us or to the producer from whom it was purchased anytime during Your free look period. Your free look period begins on the day You get Your Policy and ends ten days after a Policy Endorsement as described above is received by You. In such an event, the Policy will be rescinded and We will pay an amount equal to the total premiums paid for the Policy less any Indebtedness and Withdrawals.**

### POLICY TERMINATION

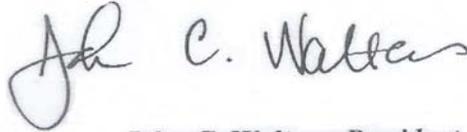
The Policy, including this Amendment, will terminate on the earliest of the following events:

1. 120 days after the Policy’s Date of Issue if a required and requested medical exam, lab test, application interview, medical report, or any other requested underwriting requirement, has not been received by Us; or
2. the date We mail You a Policy termination notice based on the non-medical evidence of insurability as provided to Us in the Application, or in any other requested non-medical underwriting insurability requirement, as part of Our underwriting review; or
3. surrender of the Policy; or
4. the end of the Policy Grace Period when premiums sufficient to keep the Policy from terminating are not paid; or
5. the date the Insured dies.

In the case of Policy termination as described in 1. and 2. above, Our liability will be limited to a refund of the total premiums paid for the Policy.

In the event any of the provisions of this Amendment conflict with any applicable provisions of the Policy, the provisions of this Amendment will control. This Amendment is part of the Policy to which it is attached and, except as noted above, it is subject to all of the terms, conditions and limitations of the Policy. All other terms and provisions of the Policy remain unchanged.

Signed for **HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

A handwritten signature in black ink that reads "John C. Walters". The signature is written in a cursive style with a large initial "J".

**John C. Walters, *President***

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SERFF Tracking Number: HARL-126610487 State: Arkansas  
 Filing Company: Hartford Life and Annuity Insurance Company State Tracking Number: 45571  
 Company Tracking Number: HL-19287(10)  
 TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life  
 Adjustable Life  
 Product Name: Binding Receipt and Amendment  
 Project Name/Number: Binding Receipt and Amendment/HL-19287(10)

## Supporting Document Schedules

	Item Status:	Status Date:
<p><b>Satisfied - Item:</b> Flesch Certification  <b>Comments:</b>  <b>Attachments:</b>            AR Cert - Rule 19 _Unfair Discrim_.pdf            Readability Certification.pdf</p>		
<p><b>Bypassed - Item:</b> Application  <b>Bypass Reason:</b> n/a for this filing  <b>Comments:</b></p>		
<p><b>Bypassed - Item:</b> Outline of Coverage  <b>Bypass Reason:</b> n/a for this filing  <b>Comments:</b></p>		
<p><b>Satisfied - Item:</b> HL-19287(10) Binding Receipt &amp; Amendment SOV  <b>Comments:</b>  <b>Attachments:</b>            Binding Receipt SOV.pdf            Amendment SOV.pdf</p>		

**ARKANSAS  
POLICY FORM CERTIFICATION**

**HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

Form Number(s), Form Title(s):  
Form HL-19287(10) Binding Receipt  
LA-1341(10) Amendment

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:



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Lenore Paoli, AVP Business Practices and Compliance

May 3, 2010  
Date

## 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.

<u>Form Number</u>	<u>Flesch Score</u>
LA-1341(10))	45.4
HL-19287(10)	50.6

Hartford Life and Annuity Insurance Company  
NAIC Number 71153-091



\_\_\_\_\_  
Signature of Insurance Company Officer

Lenore Paoli, AVP, ILD Compliance  
Typed Name and Title

**HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

**STATEMENT OF VARIABILITY**

**HL-19287(10) BINDING RECEIPT**

**04/28/2010**

Page 1	Administrative Office	We may change our administrative office address based on current company operations.
Page 1	Eligibility Requirements Item 2.	We may change the maximum face amount anywhere from \$500,000 to \$10,000,000. Such change would be made for new issues only on a nondiscriminatory basis.
Page 1	Limitations and Conditions of Coverage Item 2.	We may change the maximum age anywhere from age 60 to age 85. Such change would be made for new issues only on a nondiscriminatory basis.

**HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

**STATEMENT OF VARIABILITY**

**LA-1341(10) AMENDMENT**

**04/28/2010**

Page 2	Officer Signatures	We may change officer signatures based on current company operations.
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 Company Tracking Number: HL-19287(10)  
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 Adjustable Life  
 Product Name: Binding Receipt and Amendment  
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## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/03/2010	Form	Binding Receipt	05/04/2010	HL-19287(10).pdf (Superseded)



Hartford Life and Annuity Insurance Company  
[P.O. Box 64271, St. Paul, Minnesota 55164-0271]

## BINDING PREMIUM RECEIPT

### Definitions

The definitions in this section apply to the following words and phrases whenever and wherever they appear in this Receipt.

**Application:** means an Application for Life Insurance.

**Request:** means a Request for Insurance Application.

**Primary Insured:** means "Proposed Insured 1" named in the Application or Request, or "Proposed Insured 1" and "Proposed Insured 2" named in the Application or Request for a survivorship policy.

**We, Our, Us:** means the Hartford Life and Annuity Insurance Company

**You, Your:** means the individual applying for the life insurance policy.

### Description Of Coverage

Provided you meet all of the Eligibility Requirements described below, We agree to provide coverage under this Receipt for the Primary Insured(s) effective on the date it is signed by You.

### Eligibility Requirements

Coverage under this Receipt becomes effective on the date this Receipt is signed by You, subject to **all** of the following conditions:

1. **all answers to the Health Questions below are answered NO;**
2. the face amount of the applied for policy is less than [\$1,000,000];
3. An Application or Request has been completed as of the same date this Receipt is signed;
4. the applied for policy is not an "employer-owned life insurance contract under Internal Revenue Code Section 101(j); and
5. We receive no less than the first full modal premium for the mode selected on the Application or Request. In the event a monthly mode is selected, no less than the first three modal premiums must be received.

### Amount Of Life Insurance Coverage Under This Receipt

If death of a covered Primary Insured occurs while this Receipt is in effect, We will pay the death benefit to the beneficiary designated in the Application or Request.

### Limitations And Conditions Of Coverage Under This Receipt

1. This Receipt provides coverage only for the Primary Insured(s). **This Receipt does not provide coverage for any other proposed insureds, including, but not limited to, other proposed insureds under term insurance riders and child riders;**
2. This Receipt does not provide coverage if the Primary Insured(s) is age [66] or older on his/her birthday nearest the date this Receipt is signed;
3. This Receipt provides coverage in the event of death of the Primary Insured(s). It does not provide any coverage for **other benefits which may be applied for**, including but not limited to, accelerated death benefits, disability income benefits, or accidental death benefits;
4. There is no coverage under this Receipt if a Primary Insured dies by suicide. In this event, Our liability will be limited to a refund of the total premium paid for the Policy; and
5. **Material misrepresentations or fraud in the answers to the Health Questions set forth below or in the Application, will invalidate this Receipt and may be the basis for denial of benefits under, or rescission of, the applied for Policy.** In this event, Our liability will be limited to a refund of the total premium paid for the Policy.

**If benefits are payable under this Receipt, then no benefit relating to that loss will be payable under the applied for Policy**

You have applied for a life insurance policy with Us. If the answers to the health questions below are “no” and You provide Us with no less than the first full modal premium for the mode selected on the Application or Request (or no less than the first three full modal premiums if a monthly mode is selected), the death benefit applied for shall take effect under this Receipt in the event of death of a covered Primary Insured as a result of accidental or natural causes originating after the date this Receipt and the Application or Request is signed.

**IF ANY QUESTION BELOW IS ANSWERED “YES” OR LEFT BLANK, NO COVERAGE WILL TAKE EFFECT UNDER THIS RECEIPT AND THE TOTAL PREMIUM PAID FOR THE POLICY WILL BE REFUNDED.**

**The answers below apply to the Proposed Primary Insured. In the event a survivorship policy is applied for, “Primary Insured” means “Proposed Insured 1” and “Proposed Insured 2” named in the Application or Request.**

**Has the Primary Insured(s):**

1.  Yes  No ever had insurance rejected or offered with an extra premium or rating?
2.  Yes  No in the last 5 years:
  - been treated or had treatment recommended for alcohol or drug abuse;
  - been convicted of driving under the influence of alcohol and/or drugs; or
  - used any illegal drug or prescription drug that was not prescribed for you by a health care provider or used a drug prescribed to you other than as prescribed?
3.  Yes  No ever had, been treated for or had treatment recommended by a health care provider for:
  - Immune System Disease;
  - Human Immunodeficiency Virus (HIV) Infection; or
  - Acquired Immune Deficiency Syndrome (AIDS)?
4.  Yes  No ever had or been treated for, or ever been (or currently being) evaluated for or advised to seek an evaluation for:
  - Cancer
  - Kidney failure
  - Organ transplant
  - Cardiac arrest
  - Heart surgery
  - An implanted defibrillator
  - Hepatitis C
  - Progressive muscular or neurologic disease
  - Alzheimer’s disease or dementia
  - Stroke
  - Cardiomyopathy or congestive heart failure, or
  - Any lung or breathing disorder requiring oxygen
5.  Yes  No within the last 6 months, other than for pregnancy or childbirth:
  - been admitted to or treated at a hospital or other medical facility (except for routine office visits to a health care provider);
  - been advised to be admitted to or treated at a hospital or other medical facility;
  - had surgery performed or recommended;
  - had an unintentional loss of 10 pounds or more of his/her body weight; or
  - Undergone any medical testing (excluding HIV testing) or medical evaluation by a health care provider or had testing recommended for which a final diagnosis has not been determined (excluding HIV testing)?
6.  Yes  No ever been convicted of, pleaded guilty or no contest to any felony violation?

**When The Binding Premium Receipt Terminates**

Coverage under this Receipt will terminate on the earliest of the following to occur:

1. the date the policy takes effect, in which case Your initial premium payment will be applied to the policy as of the policy’s effective date;
2. the date of death of the covered Primary Insured, in which case We will pay the death benefit to the beneficiary designated in the Application or Request;
3. the date We mail a notice of termination of this Receipt to the Proposed Policyowner at the address set forth in the Application or Request; and
4. the date We receive Your written request to terminate coverage under this Receipt.

In the case of 3. and 4. above, Our liability will be limited to a refund of the total premium paid for the policy.

No agent or other company representative may waive or modify the answer to any question in the Application or Request or modify the terms or conditions of this Receipt.

**DECLARATIONS AND SIGNATURES**

Each of the undersigned declares, understands and agrees that:

- The answers provided above are complete and true to the best of his/her knowledge and belief.
- The statements and answers set forth in this Receipt are made a part of the Application for Life Insurance and are the basis for any insurance policy that may be issued. Owner, if not a Proposed Primary Insured, adopts and ratifies such statements and answers.
- If the answers to the Health Questions contained in this Receipt or Application are incorrect, incomplete or untrue, the Company will have the right to deny benefits under this Receipt, or deny benefits under, or rescind, the applied for policy.
- A copy of this Receipt shall be attached to and made a part of the policy, if issued.

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Proposed Primary Insured 1**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Proposed Primary Insured 2**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Proposed Policy Owner (if other than the Proposed Insured(s))**

**RECEIPT OF PAYMENT**

A premium payment of \$ \_\_\_\_\_ has been submitted with the Application or Request. Any check or draft is received subject to collection, and, if it is not honored when presented for payment, this receipt is void.

**All premium checks must be made payable to Hartford Life and Annuity Insurance Company. Do not make check(s) payable to the Agent or leave the payee blank.**

X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Licensed Insurance Producer

DETACH OWNER'S COPY AT TIME OF APPLICATION



Hartford Life and Annuity Insurance Company  
[P.O. Box 64271, St. Paul, Minnesota 55164-0271]

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HL-19287(10)

Printed in U.S.A.

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  - Immune System Disease;
  - Human Immunodeficiency Virus (HIV) Infection; or
  - Acquired Immune Deficiency Syndrome (AIDS)?
4.  Yes  No ever had or been treated for, or ever been (or currently being) evaluated for or advised to seek an evaluation for:
  - Cancer
  - Kidney failure
  - Organ transplant
  - Cardiac arrest
  - Heart surgery
  - An implanted defibrillator
  - Hepatitis C
  - Progressive muscular or neurologic disease
  - Alzheimer’s disease or dementia
  - Stroke
  - Cardiomyopathy or congestive heart failure, or
  - Any lung or breathing disorder requiring oxygen
5.  Yes  No within the last 6 months, other than for pregnancy or childbirth:
  - been admitted to or treated at a hospital or other medical facility (except for routine office visits to a health care provider);
  - been advised to be admitted to or treated at a hospital or other medical facility;
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Signature of Licensed Insurance Producer

DETACH OWNER'S COPY AT TIME OF APPLICATION