

SERFF Tracking Number: HARL-126813561 State: Arkansas  
Filing Company: Hartford Life and Annuity Insurance Company State Tracking Number: 46810  
Company Tracking Number: HL-19287(10)REV  
TOI: L09I Individual Life - Flexible Premium Sub-TOI: L09I.001 Single Life  
Adjustable Life  
Product Name: Revised Binding Receipt  
Project Name/Number: Revised Binding Receipt/HL-19287(10)Rev

## Filing at a Glance

Company: Hartford Life and Annuity Insurance Company

Product Name: Revised Binding Receipt SERFF Tr Num: HARL-126813561 State: Arkansas  
TOI: L09I Individual Life - Flexible Premium SERFF Status: Closed-Approved- State Tr Num: 46810  
Adjustable Life Closed  
Sub-TOI: L09I.001 Single Life Co Tr Num: HL-19287(10)REV State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Linda Bird  
Authors: Jane Chapman, Roberta Chu, Barbara Warren, Frank Durante  
Disposition Date: 09/21/2010  
Date Submitted: 09/16/2010 Disposition Status: Approved-Closed  
Implementation Date Requested: On Approval Implementation Date:  
State Filing Description:

## General Information

Project Name: Revised Binding Receipt  
Project Number: HL-19287(10)Rev  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 09/21/2010

Status of Filing in Domicile: Authorized  
Date Approved in Domicile: 09/14/2010  
Domicile Status Comments:  
Market Type: Individual  
Group Market Size:  
Group Market Type:  
Explanation for Other Group Market Type:  
State Status Changed: 09/21/2010  
Created By: Barbara Warren  
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Roberta Chu

Filing Description:

We are submitting the subject form for your review and approval. The form is intended to replace HL-19287(10) recently approved by the Department under State Tracking Number 45571, Serff tracking number HARL-126610487.

As indicated in the previously approved filing, the form has 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. This program is similar to our current process with regard to

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temporary insurance, with the only difference being delivery of the policy prior to completion of underwriting. Under the program, applicants will complete the Binding Premium Receipt, 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.

The reason for the revision of the form is to revise the Eligibility Requirements section, item number 2. We wish to revise the form to indicate that the total death benefit amount as applied for in the Application or Request together with the total death benefit amount under any other policies applied for or in-force with Us or any affiliated company on the life of the Primary Insured, is less than \$2,000,000.

Previously, the form indicated that the face amount of the applied for policy is less than \$1,000,000. With this revision we have also added the suffix "Rev" to the form number. No other changes have been made to the submitted form other than those indicated above.

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

We have also attached the Fraud Notice for information which contains the required fraud statement and will always be used in conjunction with/attached to the application.

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.

## 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: \$50.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Hartford Life and Annuity Insurance Company	\$50.00	09/16/2010	39559035

SERFF Tracking Number: HARK-126813561 State: Arkansas  
Filing Company: Hartford Life and Annuity Insurance Company State Tracking Number: 46810  
Company Tracking Number: HL-19287(10)REV  
TOI: L091 Individual Life - Flexible Premium Sub-TOI: L091.001 Single Life  
Adjustable Life  
Product Name: Revised Binding Receipt  
Project Name/Number: Revised Binding Receipt/HL-19287(10)Rev

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	09/21/2010	09/21/2010



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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	FYI - Fraud Statement Notice		Yes
Supporting Document	SOV		Yes
Form	Binding Premium Receipt		Yes

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## Form Schedule

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

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	HL-19287(10)Rev	Application/Binding Premium Enrollment Form	Receipt	Initial		50.600	HL-19287(10)Rev.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 total death benefit amount as applied for in the Application or Request together with the total death benefit amount under any other policies applied for or in-force with Us or any affiliated company on the life of the Primary Insured, is less than [\$2,000,000];
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**

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

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**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 total death benefit amount as applied for in the Application or Request together with the total death benefit amount under any other policies applied for or in-force with Us or any affiliated company on the life of the Primary Insured, is less than [\$2,000,000];
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

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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.

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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?

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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

SERFF Tracking Number: HARL-126813561 State: Arkansas  
Filing Company: Hartford Life and Annuity Insurance Company State Tracking Number: 46810  
Company Tracking Number: HL-19287(10)REV  
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Product Name: Revised Binding Receipt  
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## Supporting Document Schedules

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

Readability Certification.pdf

AR Cert - Rule 19 (Unfair Discrim).pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** FYI - Fraud Statement Notice

**Comments:**

**Attachment:**

HL-15883(10) FRAUD STATEMENT NOTICE.pdf

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** SOV

**Comments:**

**Attachment:**

Binding Receipt SOV.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  
HL-19287(10)Rev

Flesch Score  
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

**ARKANSAS  
POLICY FORM CERTIFICATION**

**HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

Form Number(s), Form Title(s):  
Form HL-19287(10)Rev Binding Receipt

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

September 16, 2010  
Date

## 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.

**HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

**STATEMENT OF VARIABILITY**

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

**09/13/2010**

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 Death Benefit 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.