

SERFF Tracking Number: HARL-127003239 State: Arkansas  
Filing Company: Hartford Life and Annuity Insurance Company State Tracking Number: 47850  
Company Tracking Number: HL-19311(11)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Application for Life Insurance  
Project Name/Number: Application for Life Insurance/HL-19311(11)

## Filing at a Glance

Company: Hartford Life and Annuity Insurance Company

Product Name: Application for Life Insurance SERFF Tr Num: HARL-127003239 State: Arkansas  
TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 47850  
Closed

Sub-TOI: L08.000 Life - Other Co Tr Num: HL-19311(11) State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Linda Bird  
Authors: Jane Chapman, Roberta Chu, Barbara Warren, Frank  
Durante Disposition Date: 02/03/2011  
Date Submitted: 02/01/2011 Disposition Status: Approved-  
Closed  
Implementation Date Requested: On Approval Implementation Date:  
State Filing Description:

## General Information

Project Name: Application for Life Insurance  
Project Number: HL-19311(11)  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:

Status of Filing in Domicile: Authorized  
Date Approved in Domicile: 01/26/2011  
Domicile Status Comments:  
Market Type: Individual  
Individual Market Type:  
Filing Status Changed: 02/03/2011  
State Status Changed: 02/03/2011  
Created By: Roberta Chu  
Corresponding Filing Tracking Number:

Deemer Date:  
Submitted By: Roberta Chu  
Filing Description:

We are submitting the subject forms for your review and approval.

The Application for Life Insurance is a new form and is not intended to replace any form previously approved by the Department. It is intended for use with individual non-variable and variable life insurance policies as approved or as may be approved by your Department. The application will be used in conjunction with our tele-interview process. The client will complete the basic information in this application and submit it to us, which will then prompt the tele-interview process, wherein we will interview the client in order to complete the fully underwritten application and application supplements previously approved by your Department so that we can begin the underwriting process.

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The Notice of Insurance Information Practices is a new form and is intended for use with this application and other applications as approved or as may be approved by your Department.

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

Best regards,

Roberta M. Chu, AIRC  
 Sr Compliance Specialist, ILD Compliance  
 Phone: (800) 503-3150 or direct (860) 843-4317  
 Fax: (860) 843-5194  
 E-Mail: roberta.chu@hartfordlife.com

## Company and Contact

### Filing Contact Information

Roberta Chu, Contract Analyst roberta.chu@hartfordlife.com  
 200 HopmeadowRd 860-843-4317 [Phone]  
 Simsbury, CT 06089 860-843-5194 [FAX]

### Filing Company Information

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

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No
Fee Explanation:	2 forms/\$50=\$100
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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Hartford Life and Annuity Insurance Company \$100.00 02/01/2011 44289894

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/03/2011	02/03/2011

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## Disposition

Disposition Date: 02/03/2011

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	Statement of Variables		Yes
Supporting Document	FYI - Fraud Notice		Yes
Form	Application for Life Insurance		Yes
Form	Notice of Insurance Information Practices		Yes

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## Form Schedule

### Lead Form Number: HL-19311(11)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	HL-19311(11)	Application/ Enrollment Form	Application for Life Insurance	Initial		50.000	HL-19311(11).pdf
	HL-19312IIP	Other	Notice of Insurance Information Practices	Initial		0.000	HL-19312IIP.pdf

# APPLICATION FOR LIFE INSURANCE

## HARTFORD LIFE AND ANNUITY INSURANCE COMPANY

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

If additional space is needed when completing any information in this Application for Life Insurance, attach an additional sheet if necessary. Such additional sheet will become part of the Application.

### SECTION 1 - POLICY INFORMATION

<b>Name of Proposed Insured 1</b>		Social Security Number	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residential Street Address (City, State, Zip) (Permanent Physical Address, No PO Box)		Mailing Address (City, State, Zip) (Only if different than Residential Street Address)		Email Address:
<b>Phone Interview Preferences</b>	Phone Number	Date	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
<b>Name of Proposed Insured 2</b>		Social Security Number	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residential Street Address (City, State, Zip) (Permanent Physical Address, No PO Box)		Mailing Address (City, State, Zip) (Only if different than Residential Street Address)		Email Address:
<b>Phone Interview Preferences</b>	Phone Number	Date	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM

<b>Owner Information</b>		
Policy Owner Name	Social/Tax ID	Date of Birth/Trust
Residential Street Address (City, State, Zip) (Permanent Physical Address, No PO Box)	Mailing Address (City, State, Zip) (Only if different than Residential Street Address)	Email Address:

<b>Beneficiary Information</b> All multiple beneficiary designations will be equally divided among beneficiaries unless otherwise indicated. You must use whole numbers only, no fractions or decimals. Percentage totals must equal 100%. (Ex. 34+33+33)		
Primary Beneficiary Name(s) (If Trust include date)	Relationship to Proposed Insured	% of Benefit

<b>Payment Mode</b> (Select one) <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Quarterly EFT <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Other _____	<b>Special Requests</b>
	<b>Requested Policy Date</b>

**SECTION 2 - PRODUCT INFORMATION**

Face Amount of Base Policy: \$ \_\_\_\_\_

**Product (Select one)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Hartford Bicentennial UL Freedom          | <input type="checkbox"/> Hartford Leaders VUL Liberty         | <input type="checkbox"/> Hartford Bicentennial Term 10 |
| <input type="checkbox"/> Hartford Bicentennial UL Founders II      | <input type="checkbox"/> Hartford Leaders VUL Legacy          | <input type="checkbox"/> Hartford Bicentennial Term 15 |
| <input type="checkbox"/> Hartford Bicentennial UL Joint Freedom II | <input type="checkbox"/> Hartford Leaders VUL Joint Legacy II | <input type="checkbox"/> Hartford Bicentennial Term 20 |
| <input type="checkbox"/> Hartford Frontier Indexed UL*             | <input type="checkbox"/> Hartford ExtraOrdinary Whole Life    | <input type="checkbox"/> Hartford Bicentennial Term 30 |
|  | <input type="checkbox"/> Annual Renewable Term                | <input type="checkbox"/> Other                         |

[\*Complete Disclosure Supplement to Application (must be signed on or before the date the application is signed and must be submitted with the application)]

**Optional Benefits**

- |   |  |
|---|--|
| <input type="checkbox"/> Accelerated Death Benefit (For Terminal Illness)*  | <input type="checkbox"/> LifeAccess Accelerated Benefit *  |
| <input type="checkbox"/> Accidental Death Benefit \$ _____  | <input type="checkbox"/> Owner Designated Settlement Option (Complete Beneficiary Designation and Designated Settlement Option Form) |
| <input type="checkbox"/> COLA   | <input type="checkbox"/> Qualified Plan (ExtraOrdinary Whole Life only)  |
| <input type="checkbox"/> Child Insurance \$ _____   | <input type="checkbox"/> Term Insurance \$ _____<br>(Proposed Insured 1, Liberty and Legacy)   |
| <input type="checkbox"/> DisabilityAccess (Available on Proposed Insured 1 only. Not available on Freedom)<br>Monthly Benefit Amount \$ _____ | <input type="checkbox"/> Term Insurance \$ _____<br>(Proposed Insured 2. Not available on Freedom. Complete Term Rider Supplement)   |
| <input type="checkbox"/> Estate Protection (Joint Legacy II and Joint Freedom II only)  | <input type="checkbox"/> Waiver of Specified Amount \$ _____   |
| <input type="checkbox"/> Extended Value Option (Founders II and Frontier only)  | <input type="checkbox"/> Deduction Amount Waiver   |
| <input type="checkbox"/> Guaranteed Minimum Accumulation Benefit (Liberty, Legacy and Joint Legacy II only) **                                | <input type="checkbox"/> Waiver of Premium (Bicentennial Term only) ]  |
| <input type="checkbox"/> Guaranteed Paid Up Death Benefit (Liberty, Legacy and Joint Legacy II only) **                                       | <input type="checkbox"/> Other (Please specify) _____  |

[\*Complete the Policy Owner Disclosure Statement (must be signed on or before the date the application is signed and must be submitted with the application.)

\*\*Select only one Guaranteed Benefit Rider]

**Death Benefit Option** (Applies to all products except Term and Whole Life) Select only one.

- Level (Option A)     Return of Account Value (Option B)     Return of Premium (Option C)

**SECTION 3 - INSURANCE IN FORCE AND PENDING** Provide details to "Yes" answers in section below.

- |  |  |
|--|--|
| a. Do any of the Proposed Insured(s) 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 "Yes", provide details below.)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Do any of the Proposed Insured(s) 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 "Yes", provide details below.)  | <input type="checkbox"/> Yes <input type="checkbox"/> 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 Proposed Insured(s) may have with The Hartford or any other carrier? (If "Yes", provide replacement details below including whether the replacement is intended to qualify as a 1035 Exchange.) Replacement includes (but is not limited to) the assignment, sale or transfer of a life insurance policy or annuity to a third party, a reduction in policy face amount or value, or the lapse, surrender or termination of a policy, up to 6 months prior or 13 months after policy issue. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

**SECTION 4 - COMPLETE THIS SECTION FOR VARIABLE LIFE INSURANCE**

<b>Proposed Policy Owner Acknowledgements</b>	
a. Do you believe that this policy will meet your insurance needs and financial objectives?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Do you understand that the amount and duration of the death benefit may vary, depending on the investment performance of the variable accounts in the separate account?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Do you understand that the policy values may increase or decrease, depending on the investment performance of the variable accounts in the separate account?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Did you receive the product prospectus for the policy applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 5 - NICOTINE USE**

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

**SECTION 6 - AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION**

I, an undersigned Proposed Insured, authorize Hartford Life and Annuity Insurance Company ("The Hartford") to complete a Personal History Interview and to obtain an Investigative Consumer Report on me (and on my minor children if they are applying for insurance). Further, I authorize the release of any medical or non-medical information that relates to me (and my minor children if they are applying for insurance) that is necessary for 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 coverages 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 understand that The Hartford may disclose medical and non-medical information about me to the owner(s) or beneficiary(ies) (or their legal representatives) of the policy and I hereby authorize such disclosure.

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 Insurance Information Practices.

**SECTION 7 - DECLARATION AND SIGNATURES** Complete for all Applications

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

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

Application Signed At: \_\_\_\_\_  
City State

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

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MO/DY/YR

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

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MO/DY/YR

3. \_\_\_\_\_  
 Signature of Owners(s) if other than  
 Proposed Insured(s)

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MO/DY/YR

4. \_\_\_\_\_  
 Additional Owner Signature

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MO/DY/YR

5. \_\_\_\_\_  
 Additional Owner Signature

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MO/DY/YR

6. \_\_\_\_\_  
 Signature of Licensed Insurance  
 Producer

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MO/DY/YR

**INSURANCE PRODUCER INFORMATION** Complete for all applications. When providing details to questions below, attach an additional sheet if necessary.

Please answer the following questions regarding the Proposed Insured(s).

1. How many years have you known the Proposed Insured(s)?

2. What is the Marital Status of the Proposed Insured?

3. Did you see all persons proposed for insurance? (If "No", provide details below.)  Yes  No

4. a. 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

b. 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

c. 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

5. 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

6. a. Do you have knowledge or reason to believe that replacement of existing life insurance or annuities is involved in this transaction?  Yes  No

b. 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

c. If replacing, give the total amount of existing life insurance that will remain in force \$ \_\_\_\_\_

7. REQUIREMENTS ORDERING—have you ordered, or will you be ordering the required medical evidence? (If "Yes", provide details below.)  Yes  No

Please check all that apply:		Insured 1	Insured 2	Paramed/APS/IR Vendor	Date Ordered
SALIVA	Oral Fluid Test	<input type="checkbox"/>	<input type="checkbox"/>		
BLDF	Blood Profile	<input type="checkbox"/>	<input type="checkbox"/>		
HOS	Urine Specimen	<input type="checkbox"/>	<input type="checkbox"/>		
PM	Paramedical Exam	<input type="checkbox"/>	<input type="checkbox"/>		
EKG	Electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>		
MD Exam	Physician's Exam	<input type="checkbox"/>	<input type="checkbox"/>		
APS	Client Medical Records	<input type="checkbox"/>	<input type="checkbox"/>		
APS	Client Medical Records	<input type="checkbox"/>	<input type="checkbox"/>		
IR	Inspection Report	<input type="checkbox"/>	<input type="checkbox"/>		
Other		<input type="checkbox"/>	<input type="checkbox"/>		

Please indicate best phone number to reach client and best time of day if we must contact client to set up an exam appointment.

Best phone number:  Home  Work  Other \_\_\_\_\_

Best time to call:  AM  Afternoon  After 6PM  Other \_\_\_\_\_

**PAYMENT INFORMATION** Complete if payment collected

8. Is advance payment being submitted with this application?  Yes  No Amount \$ \_\_\_\_\_

If Advance Premium Payment is being submitted follow these procedures:

- a. The premium collected is no less than the amount of the full first premium for the mode selected.
- b. The Temporary Insurance Agreement or Binding Premium Receipt is given and the premium is collected ONLY at the time the application is taken and signed. Temporary insurance coverage under the Temporary Insurance Agreement or Binding Premium Receipt is only available for the Proposed Insured designated as Proposed Insured 1 on the Application (or Proposed Insured 1 and Proposed Insured 2 if Survivor Life is being applied for).
- c. If the Temporary Insurance Agreement is completed:
  - (i) the Proposed Insured(s) is/are under age 70 years old or less, age nearest birthday;
  - (ii) the amount of insurance applied for does not exceed \$5,000,000 (the Temporary Insurance Agreement provides coverage to a maximum of \$1,000,000); and
  - (iii) the answers to the Health Questions are all answered "No".
- d. If the Binding Premium Receipt is completed:
  - (i) the Proposed Insured(s) is/are under age 66 years old or less, age nearest birthday;
  - (ii) the total death benefit amount as applied for 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; and
  - (iii) the answers to the Health Questions are all answered "No".
- e. The Proposed Insured(s) appear to be standard risks in all respects.
- f. The producer does not make an advance premium payment for the Proposed Insured or Applicant. If this is done, loss of the Insurance Producer's license could occur.
- g. The application does not contain a request for postdating.

Advance Premium Payment WILL NOT be accepted if the above conditions are NOT met. If all the above conditions are NOT met, do not complete a Temporary Insurance Agreement or Binding Premium Receipt.

**PRODUCER CERTIFICATION** Complete for all applications

- 1. I CERTIFY that all questions asked by me were recorded as given and they are complete and accurate to the best of my knowledge and belief.
- 2. I CERTIFY that I have reviewed photo I.D. documentation sufficient to verify the identity of the proposed Owner(s).
- 3. I CERTIFY that this customer did not exhibit any suspicious behavior that could be related to money laundering activities while applying for this policy.
- 4. I CERTIFY that this policy has not been solicited, directly or indirectly, for the benefit of an investor, stranger or unrelated third party.
- 5. I CERTIFY that I am duly licensed in the state in which this application was signed.
- 6. I have given the Proposed Insured(s) and Proposed Owner(s), if different than the Proposed Insured(s), the appropriate Disclosure documents.
- 7. For Variable Life Business, I CERTIFY that I am a FINRA Registered Representative.
- 8. I have complied with state and federal laws on disclosure, cost comparison and replacement.
- 9. I have reviewed the purchase of this insurance policy as to suitability.

→ \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature(s) of Writing Producer(s) Month Day Year

Insurance Producer E-mail address \_\_\_\_\_



**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 and Annuity Insurance Company 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, the MIB, Inc. upon request will supply such a company, with the information in its file. Upon receipt of a request from you, the MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact the MIB, Inc. at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in the MIB, Inc.'s file, you may contact the 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](http://www.MIB.com) or by mail 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number (617) 426-3660.

**ACCESS, CORRECTION AND DISCLOSURE**

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant.

Hartford Life and Annuity Insurance Company or its reinsurer(s) may release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Also, please be advised that personal and confidential information collected by us may, in certain circumstances, be disclosed to third parties without authorization. A further description of the circumstances under which information about you may be disclosed and the types of persons and organizations to whom it may be disclosed will be sent to you upon your written request.

If you desire further information or access to your personal information, please send your written request to: Hartford Life and Annuity Insurance Company, 500 Bielenberg Drive, Woodbury, Minnesota 55125.

**INSURANCE PRODUCER: THIS NOTICE MUST BE REMOVED AND LEFT WITH THE PROPOSED INSURED(S)**

SERFF Tracking Number: HARL-127003239 State: Arkansas  
Filing Company: Hartford Life and Annuity Insurance Company State Tracking Number: 47850  
Company Tracking Number: HL-19311(11)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Application for Life Insurance  
Project Name/Number: Application for Life Insurance/HL-19311(11)

## Supporting Document Schedules

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

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

AR Certification - Rule 19.pdf

Readability Certification.pdf

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

**Satisfied - Item:** Statement of Variables

**Comments:**

**Attachment:**

Statement of Variables.pdf

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

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

**Comments:**

Attached for informational purposes is the Fraud Notice which contains the required fraud statement. The notice will always be used in conjunction with and made a part of the application.

**Attachment:**

HL-15883-1(10) FRAUD NOTICE.pdf

**ARKANSAS  
POLICY FORM CERTIFICATION**

**HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

Form Number(s): HL-19311(11), HL-19312IIP

Form Title(s): Application for Life Insurance, Notice of Insurance Information Practices

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:



\_\_\_\_\_

Date

Lenore Paoli, AVP, Business Practices and Compliance

February 1, 2011

## 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-19311(11)

Flesch Score

50.3\*, 50.0\*\*

\*when scored as part of base policy form LA-1308(08)Rev

\*\*when scored as part of base policy form LA-1252(04)

Hartford Life and Annuity Insurance Company

NAIC Number 71153-091



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

Lenore Paoli, AVP, ILD Business Practices and Compliance

Typed Name and Title

**STATEMENT OF VARIABLES**  
**for**  
**Application for Life Insurance**  
**and**  
**Notice of Insurance Information Practices**

**January 24, 2011**

The bracketed items are variable and may be modified on a non-discriminatory basis. The following information describes the usage and possible future modifications to the bracketed variable material of the captioned policy form.

**Application for Life Insurance**

<b>PAGE NUMBER</b>	<b>VARIABLE ITEM</b>	<b>DESCRIPTION</b>
Page 1	Administrative Address	Our Administrative Office address has been bracketed to allow for future address changes.
Page 1	Payment Mode	The Payment Mode has been bracketed to allow us to discontinue or add payment modes.
Page 2	Section 2 – Product Information for Product and Optional Benefits	Product section - the product names have been bracketed to allow for different marketing name(s) to be substituted. Product and Optional Benefits sections - have been bracketed to allow us to (a) delete products or optional benefits in the event we discontinue such offerings, or (b) add new products or optional benefits which have been first filed and approved by the Department.
Page 3	Section 4 – for Variable Life Insurance	When this Application is being completed for variable life insurance, this section will appear/be completed.
Page 4	Section 7 – Declarations and Signatures	When this Application is being completed for employer-owned life insurance under IRC Section 101(j), item number 7 will need to be acknowledged.

**Notice of Insurance Information Practices**

<b>VARIABLE ITEM</b>	<b>DESCRIPTION</b>
Administrative Address	Our Administrative Office address has been bracketed to allow for future address changes.

## 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.

#### **OKLAHOMA:**

Any person who knowingly, and with intent to injury, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

#### **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.