

**State:** Arkansas **Filing Company:** John Alden Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Application for Policy Change or Reinstatement - JALIC  
**Project Name/Number:** Application for Policy Change or Reinstatement- Fortis/HL-19305(08/12)

## Filing at a Glance

Company: John Alden Life Insurance Company  
Product Name: Application for Policy Change or Reinstatement - JALIC  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 12/14/2012  
SERFF Tr Num: HARL-128809493  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: HL-19305(08/12) - JALIC

Implementation  
Date Requested:  
Author(s): Jane Chapman, Roberta Chu, Barbara Warren  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 12/18/2012  
Disposition Status: Approved-Closed  
Implementation Date:

State Filing Description:

**State:** Arkansas **Filing Company:** John Alden Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Application for Policy Change or Reinstatement - JALIC  
**Project Name/Number:** Application for Policy Change or Reinstatement- Fortis/HL-19305(08/12)

## General Information

Project Name: Application for Policy Change or Reinstatement- Status of Filing in Domicile: Pending Fortis

Project Number: HL-19305(08/12)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 12/18/2012

State Status Changed: 12/18/2012

Deemer Date:

Created By: Barbara Warren

Submitted By: Roberta Chu

Corresponding Filing Tracking Number:

### Filing Description:

Hartford Life and Annuity Insurance Company submits the subject form for review and approval on behalf of John Alden Life Insurance for whom we provide administrative services pursuant to applicable administrative services agreements.

The form is intended to replace form HL-19305(04-11) previously approved by the Department in 2011. Please note this identical form has been filed for Time Insurance Company and Union Security Insurance Company this same day under separate SERFF submissions. We suggest that you review the three submissions together, thank you.

Application for Policy Change and Reinstatement is intended for use with in-force individual life insurance policies as approved or as may be approved by your Department to make policy changes. The main reason we are submitting the form is to update the MIB language in the authorization section as well as taking this opportunity to update language and reformat.

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

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

We are including for your information the Insurance Producer Information (agent report) with required replacement questions and agent certifications.

Your review and approval of this submission is greatly appreciated

## 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]

**State:** Arkansas **Filing Company:** John Alden Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Application for Policy Change or Reinstatement - JALIC  
**Project Name/Number:** Application for Policy Change or Reinstatement- Fortis/HL-19305(08/12)

**Filing Company Information**

|                                   |                         |                              |
|-----------------------------------|-------------------------|------------------------------|
| John Alden Life Insurance Company | CoCode: 65080           | State of Domicile: Wisconsin |
| 200 Hopmeadow Rd                  | Group Code: 19          | Company Type: Life           |
| Simsbury, CT 06089                | Group Name:             | State ID Number:             |
| (860) 843-9708 ext. [Phone]       | FEIN Number: 41-0999752 |                              |

**Filing Fees**

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

| Company                           | Amount  | Date Processed | Transaction # |
|-----------------------------------|---------|----------------|---------------|
| John Alden Life Insurance Company | \$50.00 | 12/14/2012     | 65761975      |

State: Arkansas Filing Company: John Alden Life Insurance Company  
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
Product Name: Application for Policy Change or Reinstatement - JALIC  
Project Name/Number: Application for Policy Change or Reinstatement- Fortis/HL-19305(08/12)

## Correspondence Summary

### Dispositions

| Status          | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 12/18/2012 | 12/18/2012     |

### Amendments

| Schedule | Schedule Item Name | Created By  | Created On | Date Submitted |
|----------|--------------------|-------------|------------|----------------|
| Form     | Application        | Roberta Chu | 12/18/2012 | 12/18/2012     |

SERFF Tracking #:

HARL-128809493

State Tracking #:

Company Tracking #:

HL-19305(08/12) - JALIC

State:

Arkansas

Filing Company:

John Alden Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Application for Policy Change or Reinstatement - JALIC

Project Name/Number:

Application for Policy Change or Reinstatement- Fortis/HL-19305(08/12)

## Disposition

Disposition Date: 12/18/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

| Schedule            | Schedule Item               | Schedule Item Status | Public Access |
|---------------------|-----------------------------|----------------------|---------------|
| Supporting Document | Flesch Certification        |                      | Yes           |
| Supporting Document | Application                 |                      | No            |
| Supporting Document | Fortis Producer Information |                      | Yes           |
| Supporting Document | SOV                         |                      | Yes           |
| Supporting Document | Fraud HL-15883(12)          |                      | Yes           |
| Form (revised)      | Application                 |                      | Yes           |
| Form                | Application                 | Replaced             | Yes           |

**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** Application for Policy Change or Reinstatement - JALIC  
**Project Name/Number:** Application for Policy Change or Reinstatement- Fortis/HL-19305(08/12)

**Filing Company:** John Alden Life Insurance Company

## Amendment Letter

Submitted Date: 12/18/2012

Comments:

Subsequent to submission, we realized that the 30 month authorization time period was bracketed. We did not intend this and have removed the square brackets.

Changed Items:

### Form Schedule Item Changes:

| Form Schedule Item Changes |             |                 |           |             |                      |                   |  |   |
|----------------------------|-------------|-----------------|-----------|-------------|----------------------|-------------------|--|---|
| Item No.                   | Form Name   | Form Number     | Form Type | Form Action | Action Specific Data | Readability Score | Attachments  | Submitted                                     |
| 1                          | Application | HL-19305(08/12) | AEF       | Initial     |                      | 50.800            | HL-19305_08-12_.pdf  | Date Submitted: 12/18/2012<br>By:             |
| <i>Previous Version</i>    |             |                 |           |             |                      |                   |  |   |
| 1                          | Application | HL-19305(08/12) | AEF       | Initial     |                      | 50.800            | HL-19305_08-12_ - CW Policy Change & Reinstatement App Final.pdf | Date Submitted: 12/14/2012<br>By: Roberta Chu |

No Rate Schedule Items Changed.

No Supporting Documents Changed.

SERFF Tracking #:

HARL-128809493

State Tracking #:

Company Tracking #:

HL-19305(08/12) - JALIC

State: Arkansas

Filing Company:

John Alden Life Insurance Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: Application for Policy Change or Reinstatement - JALIC

Project Name/Number: Application for Policy Change or Reinstatement- Fortis/HL-19305(08/12)

## Form Schedule

Lead Form Number: HL-19305(08/12)

| Item No. | Schedule Item Status | Form Name   | Form Number     | Form Type | Form Action | Action Specific Data | Readability Score | Attachments         |
|----------|----------------------|-------------|-----------------|-----------|-------------|----------------------|-------------------|---------------------|
| 1        |                      | Application | HL-19305(08/12) | AEF       | Initial     |                      | 50.800            | HL-19305_08-12_.pdf |

### Form Type Legend:

|             |   |             |  |
|-------------|---|-------------|--|
| <b>ADV</b>  | Advertising   | <b>AEF</b>  | Application/Enrollment Form                              |
| <b>CER</b>  | Certificate   | <b>CERA</b> | Certificate Amendment, Insert Page, Endorsement or Rider |
| <b>DDP</b>  | Data/Declaration Pages  | <b>FND</b>  | Funding Agreement (Annuity, Individual and Group)        |
| <b>MTX</b>  | Matrix  | <b>NOC</b>  | Notice of Coverage                                       |
| <b>OTH</b>  | Other   | <b>OUT</b>  | Outline of Coverage                                      |
| <b>PJK</b>  | Policy Jacket   | <b>POL</b>  | Policy/Contract/Fraternal Certificate                    |
| <b>POLA</b> | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | <b>SCH</b>  | Schedule Pages   |

- John Alden Life Insurance Company
- Time Insurance Company
- Union Security Insurance Company

(herein referred to as "the Company")

Administrator Hartford Life and Annuity Insurance Company ("The Hartford")



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

## APPLICATION FOR POLICY CHANGE OR REINSTATEMENT

Questions? Call [Customer Service at [1-800-800-2000, Extension 13028].

### 1. POLICY INFORMATION Complete this section for all applications.

|                  |                    |
|------------------|--------------------|
| a. Policy Number | b. Name of Insured |
|------------------|--------------------|

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

### 2. TYPE OF REQUEST Select the appropriate option. For requests that require underwriting, complete all sections of this form. For requests that do not require underwriting, complete sections 1-3 and 13-15.

|   |   |
|---|---|
| <p>a. Requests that <b>Require</b> Underwriting</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Reinstate lapsed policy</li> <li><input type="checkbox"/> Increase face amount to: \$ _____</li> <li><input type="checkbox"/> Increase the following benefits:<br/>_____</li> <li><input type="checkbox"/> Change death benefit option to: <ul style="list-style-type: none"> <li><input type="radio"/> Level (Option A)</li> <li><input type="radio"/> Return of account value (Option B)</li> <li><input type="radio"/> Other: _____</li> </ul> </li> <li><input type="checkbox"/> Change risk information: <ul style="list-style-type: none"> <li><input type="radio"/> Improve risk class</li> <li><input type="radio"/> Remove or reduce rating or Aviation Exclusion Rider</li> </ul> </li> </ul> | <p>b. Requests that <b>Do Not Require</b> Underwriting</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Decrease face amount to: \$ _____</li> <li><input type="checkbox"/> Remove or reduce the following riders or benefits:<br/>_____</li> </ul> <p>c. Other Requests; <b>May Require</b> Underwriting.<br/>Describe the request below:<br/>_____</p> |
|---|---|

### 3. PREMIUM INFORMATION Complete this section for all applications.

|   |  |  |
|---|--|--|
| <p>a. Premium Mode</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Monthly EFT*                      <input type="checkbox"/> Semiannual bill</li> <li><input type="checkbox"/> Quarterly bill                        <input type="checkbox"/> Annual bill</li> <li><input type="checkbox"/> Quarterly EFT*                      <input type="checkbox"/> Non-billed</li> </ul> <p>* If this policy is not already set up for EFT payments, complete and submit an EFT request form. Quarterly EFT is not available for all policies.</p> | <p>b. Modal Premium<br/>(Amount per payment)</p> <p>\$ _____</p> | <p>c. Total Annual Premium</p> <p>\$ _____</p> |
|---|--|--|

**Application for Policy Change or Reinstatement**

**4. INSURED 1 INFORMATION**

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

|  |                             |  |   |                              |
|--|-----------------------------|--|---|------------------------------|
| a. Name of Insured (First, Middle, and Last)   |                             | b. Social Security Number  |   |                              |
| c. Date of Birth / /   | d. State/Country of Birth   |  | e. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |                              |
| f. Residential Address (Permanent Physical Address, unable to accept P.O. Box)   |                             | g. Mailing Address (If different from Residential Address)                           |   |                              |
| h. Daytime Phone Number ( )  | i. Evening Phone Number ( ) |  | j. Alternate Phone Number ( )   |                              |
| k. Preferred Phone Number to Call<br><input type="checkbox"/> Daytime <input type="checkbox"/> Alternate<br><input type="checkbox"/> Evening |                             | l. Preferred Time to Call<br><input type="checkbox"/> am <input type="checkbox"/> pm | m. Height<br>ft. in.  | n. Weight<br>lb.             |
| o. Driver's License, State ID, or Passport Number  | p. State/Country of Issue   | q. Expiration Date   | r. Gross Annual Income<br>\$  | s. Estimated Net Worth<br>\$ |
| t. Employer  | u. Occupation               | v. Duties  |   |                              |

**5. ADDITIONAL INSUREDS**

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

|  |                           |   |                              |   |                  |
|--|---------------------------|---|------------------------------|---|------------------|
| a. Name of Insured 2 (First, Middle, and Last)   |                           | b. Social Security Number   |                              | c. Type of Coverage:<br><input type="checkbox"/> Child Rider<br><input type="checkbox"/> Additional Insured |                  |
| d. Residential Address (Permanent Physical Address, unable to accept P.O. Box) and Phone |                           |   |                              |   |                  |
| e. Date of Birth / /   | f. State/Country of Birth | g. Gender<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female |                              | h. Height<br>ft. in.  | i. Weight<br>lb. |
| j. Driver's License, State ID, or Passport Number  | k. State/Country of Issue | l. Expiration Date  | m. Gross Annual Income<br>\$ | n. Estimated Net Worth  |                  |
| o. Employer  | p. Occupation             | q. Duties   |                              |   |                  |

|  |                           |   |                              |   |                  |
|--|---------------------------|---|------------------------------|---|------------------|
| a. Name of Insured 3 (First, Middle, and Last)   |                           | b. Social Security Number   |                              | c. Type of Coverage:<br><input type="checkbox"/> Child Rider<br><input type="checkbox"/> Additional Insured |                  |
| d. Residential Address (Permanent Physical Address, unable to accept P.O. Box) and Phone |                           |   |                              |   |                  |
| e. Date of Birth / /   | f. State/Country of Birth | g. Gender<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female |                              | h. Height<br>ft. in.  | i. Weight<br>lb. |
| j. Driver's License, State ID, or Passport Number  | k. State/Country of Issue | l. Expiration Date  | m. Gross Annual Income<br>\$ | n. Estimated Net Worth<br>\$  |                  |
| o. Employer  | p. Occupation             | q. Duties   |                              |   |                  |

**Application for Policy Change or Reinstatement**

|  |                           |   |                              |   |  |
|--|---------------------------|---|------------------------------|---|--|
| a. Name of Insured 4 (First, Middle, and Last)   |                           | b. Social Security Number   |                              | c. Type of Coverage:<br><input type="checkbox"/> Child Rider<br><input type="checkbox"/> Additional Insured |  |
| d. Residential Address (Permanent Physical Address, unable to accept P.O. Box) and Phone |                           |   |                              |   |  |
| e. Date of Birth / /   | f. State/Country of Birth | g. Gender<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | h. Height<br>ft.      in.    | i. Weight<br>lb.  |  |
| j. Driver's License, State ID, or Passport Number  | k. State/Country of Issue | l. Expiration Date  | m. Gross Annual Income<br>\$ | n. Estimated Net Worth<br>\$  |  |
| o. Employer  | p. Occupation             | q. Duties   |                              |   |  |

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

a. Within the past 5 years, have you used any form of tobacco, nicotine or nicotine replacement therapy (for example -- cigarette, cigar, pipe, chewing tobacco, Nicorette gum, nicotine patch, or nasal spray)?

|                | Insured 1 Name:  | Insured 2 Name:  | Insured 3 Name:  | Insured 4 Name:  |
|----------------|--|--|--|--|
| Within 12 mos. | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             |
| Within 3 years | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             |
| Within 5 years | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

Insured 1: \_\_\_\_\_ Type: \_\_\_\_\_ Amount per day: \_\_\_\_\_

Insured 2: \_\_\_\_\_ Type: \_\_\_\_\_ Amount per day: \_\_\_\_\_

Insured 3: \_\_\_\_\_ Type: \_\_\_\_\_ Amount per day: \_\_\_\_\_

Insured 4: \_\_\_\_\_ Type: \_\_\_\_\_ Amount per day: \_\_\_\_\_

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

Name of Insured (First, Middle, and Last)

|   |  |
|---|--|
| a. Are you a U.S. citizen? If not, what type of visa do you have? _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Have you ever engaged in or do you plan to engage in any aviation activity, other than as a fare-paying passenger? (If "Yes", complete Aviation Supplement)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. In the past two years, did you participate in, or do you plan to participate in skin or scuba diving; land or water vehicle competition or racing; sky diving; hang gliding or ballooning; rock or mountain climbing; or any other sports or activities that would be considered an extreme physical risk or contain a high level of physical danger? (If "Yes", complete Avocation Supplement). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Have you had insurance rejected or offered with an extra premium or rated?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Do you plan to travel or reside outside the United States within the next two years? (If "Yes", state when, where and how long)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Has your driver's license ever been suspended or revoked?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Within the past 3 years, have you been convicted of, pled guilty or no contest to three or more moving violations and/or accidents?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Within the past 5 years, have you been convicted of, pled guilty or no contest to driving under the influence of alcohol and/or drugs?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Application for Policy Change or Reinstatement**

**7. GENERAL INFORMATION (Continued)**

|  |  |
|--|--|
| i. Have you ever been convicted of, pled guilty or no contest to a Felony or Misdemeanor other than a minor traffic violation?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. For questions g, h, and i above, do you currently have charges outstanding or violations pending? (If so, provide details in section 11)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Are you a member, or have you entered into a written agreement to become a member of the armed forces, including the reserves?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| l. During the past 5 years, have you been advised by a physician or health care provider to cease or limit excessive alcohol consumption?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m. Is all or any part of the future premium payments for this life insurance policy directly or indirectly being financed by an unrelated third party (individual or entity), or part of any loan arrangement? (If "Yes", provide details in section 11 including the name of the program, vendor and/or lender being used.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| n. Is the life insurance policy being applied for an "employer-owned life insurance contract" under IRC Section 101(j)? (See the Employer-Owned Life Insurance Information form at the end of this Application for more information)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| o. Primary physician, health care provider, or clinic:<br>Name: _____ Date of Last Visit: ____/____/____<br>Address: _____   |  |
| p. During the past 5 years, have you seen a physician or health care provider for any reason? (If "Yes", provide the physician or medical facility's name and address, date and reason for visit and results of the visit in the space provided below. If additional space is needed, provide details in Section 11)         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| q. Insured Name _____ Reason for Visit _____<br>Date of Visit _____ Results _____<br>Physician Name _____<br>Physician Address _____ Phone (____) _____  |  |
| r. Insured Name _____ Reason for Visit _____<br>Date of Visit _____ Results _____<br>Physician Name _____<br>Physician Address: _____ Phone (____) _____   |  |
| s. Insured Name _____ Reason for Visit _____<br>Date of Visit _____ Results _____<br>Physician Name _____<br>Physician Address _____ Phone (____) _____  |  |

**8. MEDICAL QUESTIONS**

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

Name of Insured (First, Middle, and Last) \_\_\_\_\_

|   |  |
|---|--|
| a. Do you take any prescription medication, over-the-counter medication, or herbal remedy? If you answer Yes, provide the names and doses.  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Have you ever had, been treated for, or had treatment recommended by a member of the medical profession for:   |  |
| 1. High blood pressure; heart murmur or heart valve abnormality; chest pain; heart surgery: heart attack; abnormal heart rhythm; other heart or vascular disease, condition or disorder; stroke or mini-stroke (TIA)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Cancer; tumor or other abnormal growth; recurrent infections; lymph gland swelling or enlargement, immune system disease?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Diabetes or other endocrine disease, condition or disorder (e.g. thyroid, adrenal, pituitary, etc.)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Anemia; blood transfusion; blood vessel disease; other blood disease, condition or disorder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Application for Policy Change or Reinstatement**

**8. MEDICAL QUESTIONS (Continued)**

|   |  |
|---|--|
| 5. Dizziness; fainting or loss of consciousness; Alzheimer's disease or dementia; epilepsy or seizure disorder; brain or spinal cord disorder; other nervous system disease; depression; anxiety; stress or panic attacks; or other psychological disease, condition or disorder?                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Asthma; chronic bronchitis or emphysema; other lung disease condition or disorder; sleep apnea or narcolepsy?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Disease of the esophagus, pancreas or stomach; ulcerative colitis or Crohn's disease; chronic indigestion, diarrhea or vomiting; hepatitis or other disease of the liver; hernia, other gastrointestinal disease, condition or disorder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Bladder disease, kidney disease, prostate disease, sugar, protein or blood in the urine, breast disease, other genitourinary disease, condition or disorder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Rheumatoid arthritis, lupus, other connective tissue disease, condition or disorder, arthritis, rheumatism or other joint disease, condition or disorder; disease, condition or disorder of bones, back or spine; disease condition or disorder of muscles, ligaments or tendons?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Ear disease or eye disease, condition or disorder?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Chronic fatigue, fibromyalgia or myalgia?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. To the best of your knowledge and belief, have you ever been diagnosed or treated by a member of the medical profession as having acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or AIDs-related conditions?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Have you had a consultation, treatment or examination by a physician, health care provider or clinic for any reason not listed above?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Do you have any reason to believe that you are not currently in good health? Good health is defined as a state in which there is no current or pending need for the services of a member of the medical profession for reasons other than for conditions such as a common cold or an annual physical exam. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Do you engage in regular exercise? If you answer Yes, provide details in Section 11.   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Have you lost 10 or more pounds in the last 6 months (unrelated to a change in diet)?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. In the past 5 years, have you used any illicit drug or prescription drug that was not prescribed by a physician? If you answer Yes, provide details in Section 11, including any treatment recommended or given.   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Do you currently consume alcoholic beverages? If you answer Yes, describe how many per day and per week.   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Have you ever been treated or counseled, or had treatment recommended that was not completed, for alcohol or drug abuse?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Females only: Are you currently pregnant? If you answer yes, what is your due date?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| l. Have you lost more than 5 consecutive days of work due to any health condition in the last 3 years?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**9. GENERAL INFORMATION**

**AGE 70 AND OLDER SECTION**

Complete this section only if underwriting is required (see Section 2).

Complete a separate copy of this section for each existing and proposed insured who is age 70 or older. If you answer Yes to any questions, provide details in Section 11.

Name of Insured (First, Middle, and Last)

|  |  |
|--|--|
| a. Has any Proposed Insured undergone or is considering undergoing 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 Company designated on Page 1 of this Application or The Hartford as Administrator in connection with this application for this policy change or reinstatement? (If "Yes", please provide details in Section 11) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Has the Proposed Policy Owner or any Proposed Insured(s) been offered or promised any incentive (financial or otherwise) as an inducement to change or reinstate the proposed policy such as (but not limited to) zero cost or no cost life insurance or other cash payments? (If "Yes", please provide details in Section 11)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Application for Policy Change or Reinstatement**

**9. GENERAL INFORMATION AGE 70 AND OLDER SECTION (Continued)**

|   |   |
|---|---|
| <p>c. Has the Proposed Policy Owner or any Proposed Insured had any discussions about establishing an ownership or beneficiary designation, either now or in the future, which would provide beneficial interest from this policy to individuals or entities that do not have an insurable interest in the life of the Proposed Insured(s)? (This would include, but is not limited to, any discussions regarding a change in beneficial interest within a trust.) Essentially, insurable interest would require that the individuals be related by blood or marriage, hold a substantial interest engendered by love and affection, have a legal and substantial economic interest in the continued life of the insured(s), or have a business relationship that is not enhanced in value by the death of the insured. (If "Yes", provide details in Section 11)</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>d. Is the Proposed Policy Owner or any Proposed Insured(s) considering assigning or transferring rights or interest in this policy now or in the future, including ownership or beneficiary interests, to an investor, stranger or unrelated third party such as (but not limited to) a collateral assignment, life settlement, viatical, bank, and/or lending or investment company? (If "Yes", provide details in Section 11)</p>  | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>e. Has the Proposed Policy Owner or any Proposed Insured(s) had any discussions or consider entering into any arrangement that requires or allows the Proposed Policy Owner to relinquish ownership (either now or in the future) in the ownership arrangement of the policy or, if ownership of the proposed policy will be a trust, amend the trust arrangement after the proposed policy is issued? (If "Yes", provide details in Section 11)</p>   | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>f. Is the proposed policy being changed or reinstated at the request of or for the benefit of an investor, stranger or unrelated third party? (If "Yes", provide details in Section 11)</p>  | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |

**10. LIFE INSURANCE IN FORCE AND PENDING**

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

Name of Insured (First, Middle, and Last)

|  |   |
|--|---|
| <p>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 you answer Yes, provide information about the company and policy in the spaces below. (If "Yes", provide details in Section 11)</p>  | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>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 you answer "Yes" provide information about the company and policy in Section 11)</p>   | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>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 Company designated on Page 1 of this Application or any other carrier? If you answered "Yes" to Question 10.c. above, provide replacement details in Section 11 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.</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |

**NOTE: Any policy issued as a result of this Application will contain a suicide exclusion provision and a provision allowing for a two-year period in which to contest the validity of the policy on the basis of application misstatements (subject to any credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy, if provided for in state law). In replacing an existing policy, you should consider the fact that new suicide and contestability periods will apply.**

|   |  |
|---|--|
| <p>d. Company _____</p>   | <p>Policy Number _____</p>   |
| <p>Insured Name _____</p>   | <p>Amount _____ Year Issued _____</p>  |
| <p>To Be Replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Type <input type="checkbox"/> Individual <input type="checkbox"/> Business <input type="checkbox"/> Group</p> |

**Application for Policy Change or Reinstatement**

**10. LIFE INSURANCE IN FORCE AND PENDING (Continued)**

e. Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Amount \_\_\_\_\_ Year Issued \_\_\_\_\_  
 To Be Replaced?  Yes  No Type  Individual  Business  Group

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

| Insured Name | Section | Question | Details |
|--------------|---------|----------|---------|
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |

**12. AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION**

I, an undersigned Proposed Insured, authorize the Company designated on Page 1 of this Application (“the Company”) and The Hartford as Administrator to complete a Personal History Interview and to obtain an Investigative Consumer Report on me (and on my minor children who are Proposed Insureds). Further, I authorize the release of any medical or non-medical information that relates to me (and my minor children who are Proposed Insureds) that is necessary for the Company and The Hartford as Administrator to underwrite my application, to service the policy that may be issued in connection with the application or to determine my eligibility and/or The Company’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 entity or person that evaluates a person’s expected mortality or life expectancy, life settlement company, consumer reporting firm, employer, accountant, motor vehicle division or the MIB, Inc. (formerly known as the Medical Information Bureau). This information may be released to the Company, The Hartford as Administrator or its legal representative. However, I understand that the MIB, Inc. will release records of information only to the Company and The Hartford as Administrator.

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

I agree that a photocopy of this authorization is as valid as the original and understand that I may receive a copy of this authorization upon request. I also agree that this authorization shall be valid for thirty (30) months from the date shown below. This authorization may be revoked upon written request, except to the extent that action has already been taken. However, I understand that revocation may be a basis for denying my insurance application and/or coverage and benefits. I also acknowledge receipt of the Company’s Notice of Insurance Information Practices.

## Application for Policy Change or Reinstatement

### 13. AUTHORIZATION TO RELEASE AND DISCLOSE INFORMATION TO INSURANCE PRODUCER

---

I/We, an undersigned Proposed Insured and Owner (if different), hereby authorize the Company designated on Page 1 of this Application ("the Company") and The Hartford as Administrator to provide information about the applied-for policy and this Life Insurance Application to the writing insurance producer and the insurance producers/agencies being compensated as a result of this policy. This information shall include, but not be limited to, personal information about me (and my minor children who are Proposed Insureds), copies of correspondence from the Company and/or The Hartford as Administrator and web access to policy information. Additionally, I authorize the servicing insurance producer to assist the Company and The Hartford as Administrator in maintaining information about my policy, such as providing updated address information and administering normal servicing producer functions allowed by the Company and The Hartford as Administrator.

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 until the earlier of the time of my death or until I notify the Company and/or The Hartford as Administrator otherwise by appointing a different servicing producer or removing the servicing producer.

### 14. DECLARATIONS AND SIGNATURES

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

---

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

1. All statements and answers contained in this application, together with any amendments and supplements, are complete and true to the best of our knowledge and belief.
2. The statements and answers set forth in this application and any amendments and supplements, are the basis for any insurance policy that may be issued. Owner, if not a Proposed Insured, adopts and ratifies such statements and answers.
3. A copy of the application and any amendments and supplements shall be attached to and be made a part of the policy, if issued.
4. The insurance policy applied for will take effect only if the Proposed Insured(s) is/are living; any amendments to the application are properly signed (in capacity if applicable), all answers set forth in the application, together with any amendments and supplements, continue to be true and complete at the time the policy is delivered, and the first full modal premium is received.
5. Only an officer of the Company designated on Page 1 of this Application can make, modify, alter or discharge the terms of the application amendments, supplements and policy, or waive any of the Company's rights or requirements.
6. Subject to the policy's Incontestability provision, if any answers on this application, or any amendment or supplement, are incorrect or untrue, the Company designated on Page 1 of this Application 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 for Policy Change or Reinstatement**

**14. DECLARATIONS AND SIGNATURES (Continued)**

Application Signed At \_\_\_\_\_ / \_\_\_\_\_  
CITY STATE

- |  |             |                                     |
|--|-------------|-------------------------------------|
| 1. _____<br>Signature of Proposed Insured 1<br>(Parent or Guardian if under 15 years of age) | Date Signed | _____/_____/_____<br>Month Day Year |
| 2. _____<br>Signature of Proposed Insured 2<br>(Parent or Guardian if under 15 years of age) | Date Signed | _____/_____/_____<br>Month Day Year |
| 3. _____<br>Signature and Title of Owner(s) if other than Proposed Insured(s)                | Date Signed | _____/_____/_____<br>Month Day Year |
| 4. _____<br>Additional Owner Signature and Title   | Date Signed | _____/_____/_____<br>Month Day Year |
| 5. _____<br>Additional Owner Signature and Title   | Date Signed | _____/_____/_____<br>Month Day Year |
| 6. _____<br>Print Name of Licensed Insurance Producer  |             |                                     |
| 7. _____<br>Signature of Licensed Insurance Producer   | Date Signed | _____/_____/_____<br>Month Day Year |

- John Alden Life Insurance Company
- Time Insurance Company
- Union Security Insurance Company

(herein referred to as "the Company")  
Administrator Hartford Life and Annuity Insurance Company ("The Hartford")



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

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

## **NOTICE OF INSURANCE INFORMATION PRACTICES**

### **INVESTIGATIVE CONSUMER REPORTS**

As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. Information gathered will not be used to determine sexual orientation. 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. You also have the right to be interviewed in connection with the preparation of the investigative consumer report and receive a copy of that report upon request.

### **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. The Company designated above or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc. (formerly known as the Medical Information Bureau), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

### **ACCESS, CORRECTION AND DISCLOSURE**

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

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

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

SERFF Tracking #:

HARL-128809493

State Tracking #:

Company Tracking #:

HL-19305(08/12) - JALIC

State: Arkansas

Filing Company:

John Alden Life Insurance Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: Application for Policy Change or Reinstatement - JALIC

Project Name/Number: Application for Policy Change or Reinstatement- Fortis/HL-19305(08/12)

### Supporting Document Schedules

|  |                      | Item Status: | Status Date: |
|--|----------------------|--------------|--------------|
| Satisfied - Item:                      | Flesch Certification |              |              |
| Comments:                              |                      |              |              |
| Attachment(s):                         |                      |              |              |
| AR Cert - Rule 19 _Unfair Discrim_.pdf |                      |              |              |
| Readability Certification.pdf          |                      |              |              |

|                   |                             | Item Status: | Status Date: |
|-------------------|-----------------------------|--------------|--------------|
| Satisfied - Item: | Fortis Producer Information |              |              |
| Comments:         |                             |              |              |
| Attachment(s):    |                             |              |              |
| Agent Report.pdf  |                             |              |              |

|                              |     | Item Status: | Status Date: |
|------------------------------|-----|--------------|--------------|
| Satisfied - Item:            | SOV |              |              |
| Comments:                    |     |              |              |
| Attachment(s):               |     |              |              |
| Statement of Variability.pdf |     |              |              |

|   |                    | Item Status: | Status Date: |
|---|--------------------|--------------|--------------|
| Satisfied - Item:                       | Fraud HL-15883(12) |              |              |
| Comments:                               |                    |              |              |
| Attachment(s):                          |                    |              |              |
| HL-15883_12_ FRAUD STATEMENT NOTICE.pdf |                    |              |              |

**ARKANSAS  
POLICY FORM CERTIFICATION**

**HARTFORD LIFE AND ANNUITY INSURANCE COMPANY**

Form Number(s): HL-19305(08/12)

Form Title(s): Application for Policy Change or Reinstatement

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

Signed:



Lenore Paoli, AVP, ILD Compliance

12/14/2012

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.

Form Number  
HL-19305(08/12)

Flesch Score  
50.8

Hartford Life and Annuity Insurance Company  
NAIC Number 71153-091



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

Lenore Paoli, AVP, and Chief Compliance Officer, IL Compliance  
Typed Name and Title

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

|                  |                                       |                                     |
|------------------|---------------------------------------|-------------------------------------|
| a. Producer Name | b. Producer Phone Number<br>(       ) | c. Producer Fax Number<br>(       ) |
|------------------|---------------------------------------|-------------------------------------|

|                  |                           |
|------------------|---------------------------|
| d. Producer Code | e. Producer Email Address |
|------------------|---------------------------|

|   |  |
|---|--|
| f. Do you have any knowledge or reason to believe that the Proposed Policyowner or Insured(s) are considering assigning or transferring rights or interest in this policy now or in the future, including ownership or beneficiary interests, to an unrelated party such as (but not limited to) a life settlement, viatical, bank and/or lending or investment company? (If "Yes," provide details.)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Do you have any knowledge or reason to believe that any discussions have occurred with the Proposed Owner, Proposed Insured, or any other individuals involved in the solicitation of the policy about establishing an ownership or beneficiary designation, either now or in the future, which would provide beneficial interest to individuals or entities that do not have an insurable interest in the life of the Proposed Insured(s)? (This would include, but not limited to, any discussions regarding a change in beneficial interest within a trust.) (If "Yes," provide details.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Do you have any knowledge or reason to believe that the proposed Policyowner or Insured(s) has been offered any financial incentives as inducements to apply for this policy such as (but not limited to) premium loans or other payments equal to or in excess of the premium? (If "Yes," provide details.)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Do you have any knowledge or reason to believe that any of the Proposed Insureds have undergone or are considering to undergo any life expectancy evaluation and/or calculation as well as any analysis of the Insured's expected mortality from an individual or entity other than the Company designated on Page 1 of this Application in connection with the application for this policy?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Do you have knowledge or reason to believe that replacement of existing life insurance or annuities is involved in this transaction?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Do you have any knowledge or reason to believe that all or any part of a policy that has been, or is in the process of being, sold to an unrelated third party, including but not limited to a life settlement, viatical, bank and/or lending or investment company, is or will be replaced by this life insurance policy. (If "Yes," provide details.)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

m. Have any medical requirements been ordered?

No

Yes. Please describe the type and date ordered:

---



---



---



---



**STATEMENT OF VARIABLES**

**12/12/2012**

**APPLICATION FOR POLICY CHANGE OR REINSTATEMENT**

**Variability denoted with square brackets**

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.

| <b>VARIABLE ITEM</b>                                    | <b>DESCRIPTION</b>                                       |
|---|--|
| <b>Service Operations Address,<br/>telephone number</b> | Will vary based on changes in future company operations. |

## FRAUD STATEMENT NOTICE

**THE LAWS OF THE FOLLOWING STATES REQUIRE THAT WE PROVIDE THIS FRAUD STATEMENT NOTICE TO YOU AS PART OF 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.

### **MAINE:**

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.

### **MARYLAND:**

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

**SERFF Tracking #:**

HARL-128809493

**State Tracking #:****Company Tracking #:**

HL-19305(08/12) - JALIC

**State:**

Arkansas

**Filing Company:**

John Alden Life Insurance Company

**TOI/Sub-TOI:**

L08 Life - Other/L08.000 Life - Other

**Product Name:**

Application for Policy Change or Reinstatement - JALIC

**Project Name/Number:**

Application for Policy Change or Reinstatement- Fortis/HL-19305(08/12)

## 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 Item Status   | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s)  |
|---------------|------------------------|----------|--------------------|---------------------------|---|
| 12/13/2012    | Replaced<br>12/18/2012 | Form     | Application        | 12/18/2012                | HL-19305_08-12_ - CW Policy Change & Reinstate App Final.pdf (Superseded) |

- John Alden Life Insurance Company
- Time Insurance Company
- Union Security Insurance Company

(herein referred to as "the Company")

Administrator Hartford Life and Annuity Insurance Company ("The Hartford")



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

## APPLICATION FOR POLICY CHANGE OR REINSTATEMENT

Questions? Call [Customer Service at [1-800-800-2000, Extension 13028].

### 1. POLICY INFORMATION Complete this section for all applications.

|  |                    |
|--|--------------------|
| a. Policy Number   | b. Name of Insured |
| c. Is there a companion application for another insured?   |                    |
| <input type="checkbox"/> No <input type="checkbox"/> Yes. Please provide details about that application, including the name of the proposed insured: |                    |

### 2. TYPE OF REQUEST Select the appropriate option. For requests that require underwriting, complete all sections of this form. For requests that do not require underwriting, complete sections 1–3 and 13–15.

|  |   |
|--|---|
| a. Requests that <b>Require</b> Underwriting <ul style="list-style-type: none"> <li><input type="checkbox"/> Reinstate lapsed policy</li> <li><input type="checkbox"/> Increase face amount to: \$ _____</li> <li><input type="checkbox"/> Increase the following benefits:<br/>_____</li> <li><input type="checkbox"/> Change death benefit option to:             <ul style="list-style-type: none"> <li><input type="radio"/> Level (Option A)</li> <li><input type="radio"/> Return of account value (Option B)</li> <li><input type="radio"/> Other: _____</li> </ul> </li> <li><input type="checkbox"/> Change risk information:             <ul style="list-style-type: none"> <li><input type="radio"/> Improve risk class</li> <li><input type="radio"/> Remove or reduce rating or Aviation Exclusion Rider</li> </ul> </li> </ul> | b. Requests that <b>Do Not Require</b> Underwriting <ul style="list-style-type: none"> <li><input type="checkbox"/> Decrease face amount to: \$ _____</li> <li><input type="checkbox"/> Remove or reduce the following riders or benefits:<br/>_____</li> </ul> |
| c. Other Requests; <b>May Require</b> Underwriting.<br>Describe the request below:<br>_____<br>_____   |   |

### 3. PREMIUM INFORMATION Complete this section for all applications.

|  |  |  |   |                                      |   |                                     |  |                                     |
|--|--|--|---|--------------------------------------|---|-------------------------------------|--|-------------------------------------|
| a. Premium Mode <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Monthly EFT*</td> <td style="width: 50%;"><input type="checkbox"/> Semiannual bill</td> </tr> <tr> <td><input type="checkbox"/> Quarterly bill</td> <td><input type="checkbox"/> Annual bill</td> </tr> <tr> <td><input type="checkbox"/> Quarterly EFT*</td> <td><input type="checkbox"/> Non-billed</td> </tr> </table> <p>* If this policy is not already set up for EFT payments, complete and submit an EFT request form. Quarterly EFT is not available for all policies.</p> | <input type="checkbox"/> Monthly EFT*    | <input type="checkbox"/> Semiannual bill | <input type="checkbox"/> Quarterly bill | <input type="checkbox"/> Annual bill | <input type="checkbox"/> Quarterly EFT* | <input type="checkbox"/> Non-billed | b. Modal Premium<br>(Amount per payment)<br>\$ _____ | c. Total Annual Premium<br>\$ _____ |
| <input type="checkbox"/> Monthly EFT*  | <input type="checkbox"/> Semiannual bill |  |   |                                      |   |                                     |  |                                     |
| <input type="checkbox"/> Quarterly bill  | <input type="checkbox"/> Annual bill     |  |   |                                      |   |                                     |  |                                     |
| <input type="checkbox"/> Quarterly EFT*  | <input type="checkbox"/> Non-billed      |  |   |                                      |   |                                     |  |                                     |

**Application for Policy Change or Reinstatement**

**4. INSURED 1 INFORMATION**

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

|  |  |  |  |   |                              |
|--|--|--|--|---|------------------------------|
| a. Name of Insured (First, Middle, and Last)   |  | b. Social Security Number  |  |   |                              |
| c. Date of Birth / /   |  | d. State/Country of Birth  |  | e. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |                              |
| f. Residential Address (Permanent Physical Address, unable to accept P.O. Box)   |  |  | g. Mailing Address (If different from Residential Address) |   |                              |
| h. Daytime Phone Number ( )  |  | i. Evening Phone Number ( )  |  | j. Alternate Phone Number ( )   |                              |
| k. Preferred Phone Number to Call<br><input type="checkbox"/> Daytime <input type="checkbox"/> Alternate<br><input type="checkbox"/> Evening |  | l. Preferred Time to Call<br><input type="checkbox"/> am <input type="checkbox"/> pm | m. Height<br>ft. in.                                       |   | n. Weight<br>lb.             |
| o. Driver's License, State ID, or Passport Number  |  | p. State/Country of Issue  | q. Expiration Date   | r. Gross Annual Income<br>\$  | s. Estimated Net Worth<br>\$ |
| t. Employer  |  | u. Occupation  |  | v. Duties   |                              |

**5. ADDITIONAL INSURED**

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

|  |   |                           |   |   |                              |
|--|---|---------------------------|---|---|------------------------------|
| a. Name of Insured 2 (First, Middle, and Last)   |   | b. Social Security Number |   | c. Type of Coverage:<br><input type="checkbox"/> Child Rider<br><input type="checkbox"/> Additional Insured |                              |
| d. Residential Address (Permanent Physical Address, unable to accept P.O. Box) and Phone |   |                           |   |   |                              |
| e. Date of Birth / /   |   | f. State/Country of Birth | g. Gender<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female |   | h. Height<br>ft. in.         |
| i. Weight<br>lb.   | j. Driver's License, State ID, or Passport Number |                           | k. State/Country of Issue   | l. Expiration Date  | m. Gross Annual Income<br>\$ |
| n. Estimated Net Worth<br>\$   |   | o. Employer               |   | p. Occupation   |                              |
|  |   |                           |   | q. Duties   |                              |
| a. Name of Insured 3 (First, Middle, and Last)   |   | b. Social Security Number |   | c. Type of Coverage:<br><input type="checkbox"/> Child Rider<br><input type="checkbox"/> Additional Insured |                              |
| d. Residential Address (Permanent Physical Address, unable to accept P.O. Box) and Phone |   |                           |   |   |                              |
| e. Date of Birth / /   |   | f. State/Country of Birth | g. Gender<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female |   | h. Height<br>ft. in.         |
| i. Weight<br>lb.   | j. Driver's License, State ID, or Passport Number |                           | k. State/Country of Issue   | l. Expiration Date  | m. Gross Annual Income<br>\$ |
| n. Estimated Net Worth<br>\$   |   | o. Employer               |   | p. Occupation   |                              |
|  |   |                           |   | q. Duties   |                              |

**Application for Policy Change or Reinstatement**

|  |                           |   |                              |   |  |
|--|---------------------------|---|------------------------------|---|--|
| a. Name of Insured 4 (First, Middle, and Last)   |                           | b. Social Security Number   |                              | c. Type of Coverage:<br><input type="checkbox"/> Child Rider<br><input type="checkbox"/> Additional Insured |  |
| d. Residential Address (Permanent Physical Address, unable to accept P.O. Box) and Phone |                           |   |                              |   |  |
| e. Date of Birth / /   | f. State/Country of Birth | g. Gender<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | h. Height<br>ft.      in.    | i. Weight<br>lb.  |  |
| j. Driver's License, State ID, or Passport Number  | k. State/Country of Issue | l. Expiration Date  | m. Gross Annual Income<br>\$ | n. Estimated Net Worth<br>\$  |  |
| o. Employer  | p. Occupation             | q. Duties   |                              |   |  |

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

a. Within the past 5 years, have you used any form of tobacco, nicotine or nicotine replacement therapy (for example -- cigarette, cigar, pipe, chewing tobacco, Nicorette gum, nicotine patch, or nasal spray)?

|                | Insured 1 Name:  | Insured 2 Name:  | Insured 3 Name:  | Insured 4 Name:  |
|----------------|--|--|--|--|
| Within 12 mos. | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             |
| Within 3 years | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             | <input type="checkbox"/> Yes                             |
| Within 5 years | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

Insured 1: \_\_\_\_\_ Type: \_\_\_\_\_ Amount per day: \_\_\_\_\_

Insured 2: \_\_\_\_\_ Type: \_\_\_\_\_ Amount per day: \_\_\_\_\_

Insured 3: \_\_\_\_\_ Type: \_\_\_\_\_ Amount per day: \_\_\_\_\_

Insured 4: \_\_\_\_\_ Type: \_\_\_\_\_ Amount per day: \_\_\_\_\_

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

Name of Insured (First, Middle, and Last)

|   |  |
|---|--|
| a. Are you a U.S. citizen? If not, what type of visa do you have? _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Have you ever engaged in or do you plan to engage in any aviation activity, other than as a fare-paying passenger? (If "Yes", complete Aviation Supplement)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. In the past two years, did you participate in, or do you plan to participate in skin or scuba diving; land or water vehicle competition or racing; sky diving; hang gliding or ballooning; rock or mountain climbing; or any other sports or activities that would be considered an extreme physical risk or contain a high level of physical danger? (If "Yes", complete Avocation Supplement). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Have you had insurance rejected or offered with an extra premium or rated?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Do you plan to travel or reside outside the United States within the next two years? (If "Yes", state when, where and how long)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Has your driver's license ever been suspended or revoked?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Within the past 3 years, have you been convicted of, pled guilty or no contest to three or more moving violations and/or accidents?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Within the past 5 years, have you been convicted of, pled guilty or no contest to driving under the influence of alcohol and/or drugs?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Application for Policy Change or Reinstatement**

**7. GENERAL INFORMATION (Continued)**

|  |  |
|--|--|
| i. Have you ever been convicted of, pled guilty or no contest to a Felony or Misdemeanor other than a minor traffic violation?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. For questions g, h, and i above, do you currently have charges outstanding or violations pending? (If so, provide details in section 11)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Are you a member, or have you entered into a written agreement to become a member of the armed forces, including the reserves?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| l. During the past 5 years, have you been advised by a physician or health care provider to cease or limit excessive alcohol consumption?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m. Is all or any part of the future premium payments for this life insurance policy directly or indirectly being financed by an unrelated third party (individual or entity), or part of any loan arrangement? (If "Yes", provide details in section 11 including the name of the program, vendor and/or lender being used.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| n. Is the life insurance policy being applied for an "employer-owned life insurance contract" under IRC Section 101(j)? (See the Employer-Owned Life Insurance Information form at the end of this Application for more information)   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| o. Primary physician, health care provider, or clinic:<br>Name: _____ Date of Last Visit: ____/____/____<br>Address: _____   |  |
| p. During the past 5 years, have you seen a physician or health care provider for any reason? (If "Yes", provide the physician or medical facility's name and address, date and reason for visit and results of the visit in the space provided below. If additional space is needed, provide details in Section 11)         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| q. Insured Name _____ Reason for Visit _____<br>Date of Visit _____ Results _____<br>Physician Name _____<br>Physician Address _____ Phone (____) _____  |  |
| r. Insured Name _____ Reason for Visit _____<br>Date of Visit _____ Results _____<br>Physician Name _____<br>Physician Address: _____ Phone (____) _____   |  |
| s. Insured Name _____ Reason for Visit _____<br>Date of Visit _____ Results _____<br>Physician Name _____<br>Physician Address _____ Phone (____) _____  |  |

**8. MEDICAL QUESTIONS**

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

Name of Insured (First, Middle, and Last) \_\_\_\_\_

|   |  |
|---|--|
| a. Do you take any prescription medication, over-the-counter medication, or herbal remedy? If you answer Yes, provide the names and doses.  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Have you ever had, been treated for, or had treatment recommended by a member of the medical profession for:   |  |
| 1. High blood pressure; heart murmur or heart valve abnormality; chest pain; heart surgery: heart attack; abnormal heart rhythm; other heart or vascular disease, condition or disorder; stroke or mini-stroke (TIA)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Cancer; tumor or other abnormal growth; recurrent infections; lymph gland swelling or enlargement, immune system disease?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Diabetes or other endocrine disease, condition or disorder (e.g. thyroid, adrenal, pituitary, etc.)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Anemia; blood transfusion; blood vessel disease; other blood disease, condition or disorder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Application for Policy Change or Reinstatement**

**8. MEDICAL QUESTIONS (Continued)**

|   |  |
|---|--|
| 5. Dizziness; fainting or loss of consciousness; Alzheimer's disease or dementia; epilepsy or seizure disorder; brain or spinal cord disorder; other nervous system disease; depression; anxiety; stress or panic attacks; or other psychological disease, condition or disorder?                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Asthma; chronic bronchitis or emphysema; other lung disease condition or disorder; sleep apnea or narcolepsy?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Disease of the esophagus, pancreas or stomach; ulcerative colitis or Crohn's disease; chronic indigestion, diarrhea or vomiting; hepatitis or other disease of the liver; hernia, other gastrointestinal disease, condition or disorder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Bladder disease, kidney disease, prostate disease, sugar, protein or blood in the urine, breast disease, other genitourinary disease, condition or disorder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Rheumatoid arthritis, lupus, other connective tissue disease, condition or disorder, arthritis, rheumatism or other joint disease, condition or disorder; disease, condition or disorder of bones, back or spine; disease condition or disorder of muscles, ligaments or tendons?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Ear disease or eye disease, condition or disorder?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Chronic fatigue, fibromyalgia or myalgia?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. To the best of your knowledge and belief, have you ever been diagnosed or treated by a member of the medical profession as having acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or AIDS-related conditions?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Have you had a consultation, treatment or examination by a physician, health care provider or clinic for any reason not listed above?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Do you have any reason to believe that you are not currently in good health? Good health is defined as a state in which there is no current or pending need for the services of a member of the medical profession for reasons other than for conditions such as a common cold or an annual physical exam. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Do you engage in regular exercise? If you answer Yes, provide details in Section 11.   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Have you lost 10 or more pounds in the last 6 months (unrelated to a change in diet)?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. In the past 5 years, have you used any illicit drug or prescription drug that was not prescribed by a physician? If you answer Yes, provide details in Section 11, including any treatment recommended or given.   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Do you currently consume alcoholic beverages? If you answer Yes, describe how many per day and per week.   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Have you ever been treated or counseled, or had treatment recommended that was not completed, for alcohol or drug abuse?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Females only: Are you currently pregnant? If you answer yes, what is your due date?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| l. Have you lost more than 5 consecutive days of work due to any health condition in the last 3 years?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**9. GENERAL INFORMATION**

Complete this section only if underwriting is required (see Section 2).

**AGE 70 AND OLDER SECTION**

Complete a separate copy of this section for each existing and proposed insured who is age 70 or older. If you answer Yes to any questions, provide details in Section 11.

Name of Insured (First, Middle, and Last)

|  |  |
|--|--|
| a. Has any Proposed Insured undergone or is considering undergoing 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 Company designated on Page 1 of this Application or The Hartford as Administrator in connection with this application for this policy change or reinstatement? (If "Yes", please provide details in Section 11) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Has the Proposed Policy Owner or any Proposed Insured(s) been offered or promised any incentive (financial or otherwise) as an inducement to change or reinstate the proposed policy such as (but not limited to) zero cost or no cost life insurance or other cash payments? (If "Yes", please provide details in Section 11)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Application for Policy Change or Reinstatement**

**9. GENERAL INFORMATION AGE 70 AND OLDER SECTION (Continued)**

|   |   |
|---|---|
| <p>c. Has the Proposed Policy Owner or any Proposed Insured had any discussions about establishing an ownership or beneficiary designation, either now or in the future, which would provide beneficial interest from this policy to individuals or entities that do not have an insurable interest in the life of the Proposed Insured(s)? (This would include, but is not limited to, any discussions regarding a change in beneficial interest within a trust.) Essentially, insurable interest would require that the individuals be related by blood or marriage, hold a substantial interest engendered by love and affection, have a legal and substantial economic interest in the continued life of the insured(s), or have a business relationship that is not enhanced in value by the death of the insured. (If "Yes", provide details in Section 11)</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>d. Is the Proposed Policy Owner or any Proposed Insured(s) considering assigning or transferring rights or interest in this policy now or in the future, including ownership or beneficiary interests, to an investor, stranger or unrelated third party such as (but not limited to) a collateral assignment, life settlement, viatical, bank, and/or lending or investment company? (If "Yes", provide details in Section 11)</p>  | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>e. Has the Proposed Policy Owner or any Proposed Insured(s) had any discussions or consider entering into any arrangement that requires or allows the Proposed Policy Owner to relinquish ownership (either now or in the future) in the ownership arrangement of the policy or, if ownership of the proposed policy will be a trust, amend the trust arrangement after the proposed policy is issued? (If "Yes", provide details in Section 11)</p>   | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>f. Is the proposed policy being changed or reinstated at the request of or for the benefit of an investor, stranger or unrelated third party? (If "Yes", provide details in Section 11)</p>  | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |

**10. LIFE INSURANCE IN FORCE AND PENDING**

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

Name of Insured (First, Middle, and Last)

|  |   |
|--|---|
| <p>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 you answer Yes, provide information about the company and policy in the spaces below. (If "Yes", provide details in Section 11)</p>  | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>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 you answer "Yes" provide information about the company and policy in Section 11)</p>   | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p>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 Company designated on Page 1 of this Application or any other carrier? If you answered "Yes" to Question 10.c. above, provide replacement details in Section 11 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.</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |

**NOTE: Any policy issued as a result of this Application will contain a suicide exclusion provision and a provision allowing for a two-year period in which to contest the validity of the policy on the basis of application misstatements (subject to any credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy, if provided for in state law). In replacing an existing policy, you should consider the fact that new suicide and contestability periods will apply.**

|   |  |
|---|--|
| <p>d. Company _____</p>   | <p>Policy Number _____</p>   |
| <p>Insured Name _____</p>   | <p>Amount _____ Year Issued _____</p>  |
| <p>To Be Replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Type <input type="checkbox"/> Individual <input type="checkbox"/> Business <input type="checkbox"/> Group</p> |

**Application for Policy Change or Reinstatement**

**10. LIFE INSURANCE IN FORCE AND PENDING (Continued)**

e. Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Amount \_\_\_\_\_ Year Issued \_\_\_\_\_  
 To Be Replaced?  Yes  No Type  Individual  Business  Group

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

| Insured Name | Section | Question | Details |
|--------------|---------|----------|---------|
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |
|              |         |          |         |

**12. AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION**

I, an undersigned Proposed Insured, authorize the Company designated on Page 1 of this Application (“the Company”) and The Hartford as Administrator to complete a Personal History Interview and to obtain an Investigative Consumer Report on me (and on my minor children who are Proposed Insureds). Further, I authorize the release of any medical or non-medical information that relates to me (and my minor children who are Proposed Insureds) that is necessary for the Company and The Hartford as Administrator to underwrite my application, to service the policy that may be issued in connection with the application or to determine my eligibility and/or The Company’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 entity or person that evaluates a person’s expected mortality or life expectancy, life settlement company, consumer reporting firm, employer, accountant, motor vehicle division or the MIB, Inc. (formerly known as the Medical Information Bureau). This information may be released to the Company, The Hartford as Administrator or its legal representative. However, I understand that the MIB, Inc. will release records of information only to the Company and The Hartford as Administrator.

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

I agree that a photocopy of this authorization is as valid as the original and understand that I may receive a copy of this authorization upon request. I also agree that this authorization shall be valid for thirty [(30)] months from the date shown below. This authorization may be revoked upon written request, except to the extent that action has already been taken. However, I understand that revocation may be a basis for denying my insurance application and/or coverage and benefits. I also acknowledge receipt of the Company’s Notice of Insurance Information Practices.

## Application for Policy Change or Reinstatement

### 13. AUTHORIZATION TO RELEASE AND DISCLOSE INFORMATION TO INSURANCE PRODUCER

---

I/We, an undersigned Proposed Insured and Owner (if different), hereby authorize the Company designated on Page 1 of this Application ("the Company") and The Hartford as Administrator to provide information about the applied-for policy and this Life Insurance Application to the writing insurance producer and the insurance producers/agencies being compensated as a result of this policy. This information shall include, but not be limited to, personal information about me (and my minor children who are Proposed Insureds), copies of correspondence from the Company and/or The Hartford as Administrator and web access to policy information. Additionally, I authorize the servicing insurance producer to assist the Company and The Hartford as Administrator in maintaining information about my policy, such as providing updated address information and administering normal servicing producer functions allowed by the Company and The Hartford as Administrator.

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 until the earlier of the time of my death or until I notify the Company and/or The Hartford as Administrator otherwise by appointing a different servicing producer or removing the servicing producer.

### 14. DECLARATIONS AND SIGNATURES

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

---

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

1. All statements and answers contained in this application, together with any amendments and supplements, are complete and true to the best of our knowledge and belief.
2. The statements and answers set forth in this application and any amendments and supplements, are the basis for any insurance policy that may be issued. Owner, if not a Proposed Insured, adopts and ratifies such statements and answers.
3. A copy of the application and any amendments and supplements shall be attached to and be made a part of the policy, if issued.
4. The insurance policy applied for will take effect only if the Proposed Insured(s) is/are living; any amendments to the application are properly signed (in capacity if applicable), all answers set forth in the application, together with any amendments and supplements, continue to be true and complete at the time the policy is delivered, and the first full modal premium is received.
5. Only an officer of the Company designated on Page 1 of this Application can make, modify, alter or discharge the terms of the application amendments, supplements and policy, or waive any of the Company's rights or requirements.
6. Subject to the policy's Incontestability provision, if any answers on this application, or any amendment or supplement, are incorrect or untrue, the Company designated on Page 1 of this Application 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 for Policy Change or Reinstatement**

**14. DECLARATIONS AND SIGNATURES (Continued)**

Application Signed At \_\_\_\_\_ / \_\_\_\_\_  
CITY STATE

- |  |             |                                     |
|--|-------------|-------------------------------------|
| 1. _____<br>Signature of Proposed Insured 1<br>(Parent or Guardian if under 15 years of age) | Date Signed | _____/_____/_____<br>Month Day Year |
| 2. _____<br>Signature of Proposed Insured 2<br>(Parent or Guardian if under 15 years of age) | Date Signed | _____/_____/_____<br>Month Day Year |
| 3. _____<br>Signature and Title of Owner(s) if other than Proposed Insured(s)                | Date Signed | _____/_____/_____<br>Month Day Year |
| 4. _____<br>Additional Owner Signature and Title   | Date Signed | _____/_____/_____<br>Month Day Year |
| 5. _____<br>Additional Owner Signature and Title   | Date Signed | _____/_____/_____<br>Month Day Year |
| 6. _____<br>Print Name of Licensed Insurance Producer  |             |                                     |
| 7. _____<br>Signature of Licensed Insurance Producer   | Date Signed | _____/_____/_____<br>Month Day Year |

- John Alden Life Insurance Company
  - Time Insurance Company
  - Union Security Insurance Company
- (herein referred to as "the Company")

Administrator Hartford Life and Annuity Insurance Company ("The Hartford")



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

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

## **NOTICE OF INSURANCE INFORMATION PRACTICES**

### **INVESTIGATIVE CONSUMER REPORTS**

As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. Information gathered will not be used to determine sexual orientation. 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. You also have the right to be interviewed in connection with the preparation of the investigative consumer report and receive a copy of that report upon request.

### **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. The Company designated above or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc. (formerly known as the Medical Information Bureau), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

### **ACCESS, CORRECTION AND DISCLOSURE**

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

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

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