



g. Kidney disease, renal colic, kidney stones, syphilis, any disorder of the bladder, prostate or other genitor-urinary organs?	<input type="checkbox"/>	<input type="checkbox"/>
h. Diabetes, thyroid or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
i. Cancer, cyst or any other tumor or skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>
j. Been diagnosed as having, or been treated, by a member of the medical profession, for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
k. Any disorder of the breast, uterus, ovaries, cervix or fallopian tubes?	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate details for above questions. (Including # of episodes, duration, severity, date of last symptom, current status, treatment, results, and the name of the physician or hospital that treated you).

Item#:	Date:	Details:

4. Have you WITHIN the LAST 5 Years:	YES	NO
a. Had or been treated for any disease, injury or had an operation not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
Consulted a physician, psychiatrist or other practitioner for a general exam or any other reason not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been a patient in any hospital or sanitarium for any reason not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
5. CURRENTLY:	<input type="checkbox"/>	<input type="checkbox"/>
a. Do you drink alcohol? If YES, please indicate how often _____ How Much? _____	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you experience any symptoms, disorder or have a condition that may impair your health or require an operation?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you take any medication for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
d. Are you pregnant? (If YES, give expected delivery date and pre-pregnancy weight)	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you currently use tobacco products (including cigarettes, cigars, dip, snuff, chewing tobacco and nicotine patches or gum)? <input type="checkbox"/> Yes <input type="checkbox"/> No Which statement best describes your use of tobacco products. <input type="checkbox"/> Not within the last 4 years <input type="checkbox"/> Not within last 12 months <input type="checkbox"/> Never		

f. Current occupation: \_\_\_\_\_

During the last 3 years, have you engaged in a hazardous occupation (such as: underground mining, high-rise construction, offshore drilling, iron work, tunnel/subway construction, explosive handling, etc.)?  Yes  No

If yes, please provide details for the past three years:

Date: \_\_\_\_\_ Project/Duties: \_\_\_\_\_

Date: \_\_\_\_\_ Project/Duties: \_\_\_\_\_

Annual Salary \$ \_\_\_\_\_

g. Avocation Question:  
**Do you participate in any hazardous activities?** (Such as: aircraft flying other than as a passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, organized motorcycle racing, or any type of motorized racing)?  Yes  No

If yes, please provide details:

Please indicate details for above questions. (Including # of episodes, duration, severity, date of last symptom, current status, treatment, results, and the name of the physician or hospital that treated you).

<u>Item #:</u>	<u>Date:</u>	<u>Details:</u>
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6. Please indicate applicant's build and family history below:		Please provide the complete name and address of your primary care physician: Name: _____ Address: _____ Telephone: _____
Height	_____ ft. _____ in. (HGT & WGT without shoes)	
Weight	_____ lbs. Pulse at REST _____	

Did you measure: YES <input type="checkbox"/> NO <input type="checkbox"/>	7. Blood Pressure (Take three, 10 minutes apart and record all three) _____ Systolic: (1). (2). (3). Diastolic: (1). (2). (3).
Did you weigh: YES <input type="checkbox"/> NO <input type="checkbox"/>	
Has applicant gained or lost within the last year? +/- _____ lbs. Reason for loss or gain: _____	

Family History	AGE	Living State of Health	AGE	Not Living Cause of Death	8. Examiner Questions: a. Have you reason to believe or suspect that the proposed insured is under the influence of alcohol or narcotics? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Are you forwarding a specimen to the lab? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Which of the following did you use to identify the proposed? <input type="checkbox"/> Drivers license with picture <input type="checkbox"/> Other picture ID Please indicate below what the other picture ID is: _____
Father					
Mother					
Brothers Number ( )					
Sisters Number ( )					

I hereby declare that all statements and answers as written or printed herein are full, complete and true to the best of my knowledge and belief. I agree that they are to be considered the basis of any insurance issued hereon and no agent has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the company's rights or requirements, or to make or alter any contract.

I hereby expressly waive, to such extent as may be lawful, on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician or other person who has previously attended or examined me from disclosing any knowledge or information thereby acquired, and I expressly authorize such physician or other person to make such disclosures.

**The following fraud statement is applicable to disability insurance only:**

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Print Full Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Signature of Proposed Insured: \_\_\_\_\_ Dated: \_\_\_\_\_

Witnessed by Examiner: \_\_\_\_\_ Dated: \_\_\_\_\_

HARTFORD LIFE INSURANCE COMPANIES  
Individual Life Operations  
P.O. Box 64271  
St. Paul, Minnesota 55164-0271  
Telephone Number: (800) 246-4819



### Notification of Post-Test Counseling

I have voluntarily given my consent to the company with whom I am applying for insurance to have my bodily fluid or other specimen tested for the HIV antibody virus in connection with my application for insurance.

I have been advised of the availability of Professional and Voluntary Post-Test Counseling and the company with whom I am applying for insurance's obligation to pay the usual and customary charge for one session of Professional Counseling or Voluntary counseling, if available.

In the event of positive or indeterminate test results, and in the event that I have not designated a health care provider to receive test results, The company with whom I am applying for insurance will: 1) provide written notification to me that an abnormal test result has been obtained; 2) recommend that a health care provider be authorized to receive test results; and 3) recommend that I consult that provider.

\_\_\_\_\_  
Name of Proposed Insured (Please Print)

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
State of Residence

### Acknowledgement of Post-Test Counseling

I hereby verify that I have received Post-Test Counseling.

\_\_\_\_\_  
Name of Proposed Insured (Please Print)

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
State of Residence

The bill for one session of Post-Test Counseling may be sent to the company with whom I am applying for insurance for reimbursement at the following address:

**Hartford Life Insurance Companies**  
500 Bielenberg Drive, Woodbury, MN 55125  
Attn: Ann M. Hoven, MD

The company with whom I am applying for insurance will pay the usual and customary charge for one session of such counseling.