# The Personal Group Disability Income Protection Plan

### Especially for State IIA Association Members

## Protect ___ Your Most Important Asset

## ___ YOUR INCOME

**Make sure your family's plans can continue if your income stops.**

## Here's Why You Need Disability Insurance

- Thanks to ever-improving medical and safety technology, you're **3 times more likely to be disabled** than die during your working life from a serious illness or injury.*

- Nearly 1 in 3 people ages 35-65 will suffer a disability that lasts **90 days or longer**. 1 in 7 will be disabled **5 years or more**.**

- Health insurance only pays for covered medical expenses. **Disability Insurance helps pay for everything else** while you can't work.

### *Apply Today*

Use this plan as **basic or supplemental** protection. And if your family depends on two incomes, you can **protect your spouse too,** regardless of his or her occupation. You'll be pleased with the **outstanding features** and **affordable rates**, made possible by the group buying power of your State IIA Association.

*Clark Howard, Consumer Advocate <ClarkHoward.com> Excerpt from Radio Show 7-24-2001
** Health Insurance Association of America, (The New York Times, February, 2000)

# ANSWERS TO THE BASIC QUESTIONS ABOUT THIS PLAN

### Who is eligible?
All State IIA Association members (**owners and/or employees**) and spouses who are under age 60, are Actively at Work, have been working full time for at least 30 days prior to his or her effective date, and who reside in the United States can apply.

### What kinds of disabilities are covered?
This plan covers Total Disabilities due to accidental injuries, sickness or disease. To qualify for benefits, a period of Total Disability must begin while you are covered under this policy and you are under the regular care of a physician for that condition.

### How much income protection can I apply for?
You can insure up to 60% of the first $10,000 of your Basic Monthly Earnings. That means your benefit can be anywhere from $1,000 to $6,000 a month, in increments of $100. Benefits will be reduced by the amount of Other Income Benefits you receive at the time. (Please see the description of Other Income Benefits on the back page.)

### When do benefit payments begin?
Your benefits begin the day after the Waiting Period you select ends…either 60, 90 or 180 days.

### How long are benefits paid?
If Total Disability begins before age 60, benefits are paid for 2 years under Plan I, 5 years under Plan II or to age 65 under Plan III. You choose the plan that meets your needs and budget. If Total Disability begins at later ages, benefits are paid for 2 years or to age 70, if earlier.

### What if I need to go back to work gradually?
A Rehabilitation Benefit is included to help you rebuild your income while you attempt a gradual or partial return to work when disability benefits are payable. This monthly benefit equals your Total Disability benefit minus 50% of your partial earnings. You may receive up to 100% of your pre-disability income.

### What if I have a relapse after I return to work?
This plan is flexible enough to accommodate various disability durations and scenarios. If you return to work before the end of the Waiting Period and then suffer a relapse, you can qualify for benefits by satisfying only the remainder of the Waiting Period. You won't have to start the entire Waiting Period again. And, you won't have to satisfy a new Waiting Period to qualify for benefits if you suffer a relapse upon returning to active employment, after receiving benefits for a disability. Periods of disability, if due to the same or related medical causes and separated by fewer than six months while you are Actively At Work, are considered a single period of disability.

## IT'S SO EASY TO APPLY

1. Select Plan I, Plan II, or Plan III.
2. Choose your Waiting Period and calculate your first premium following Step 2.
3. Select your billing period (annual, semi-annual, quarterly, or monthly) and your payment method...Auto-Pay or direct bill.
4. Complete both pages of your Application.
5. Mail your application and your first payment or completed Auto-Pay authorization with a blank check marked VOID to Kelsey National Corporation in the enclosed postage paid envelope.

When your application is approved, you will receive your Certificate of Insurance. You will have 30 days to look it over and see for yourself that this plan is as good as we say it is. If for any reason you are not completely satisfied, just return the Certificate within 30 days and you will receive a full refund or credit, whichever is applicable. There's no risk on your part.

### Do I have to pay premiums while I'm disabled?
No you don't. Future premiums will be waived for as long as benefits are payable, after you have been disabled for 6 consecutive months.

### When will my coverage become effective?
Your coverage will become effective on the first day of the month immediately following the date your application is approved by the insurance company, provided you are Actively At Work and your initial premium payment has been received. If you are not Actively At Work on that date, your effective date will be the first day of the month following the date you return to active work.

*You'll find more benefit information, provisions and definitions of terms on the back page.*

## HERE'S HOW TO TAKE ADVANTAGE OF THIS VALUABLE OPPORTUNITY

### STEP I: Select the Plan That Best Meets Your Financial Security Needs

| PLAN BENEFITS | PLAN I | PLAN II | PLAN III |
|---|---|---|---|
| Maximum Insured Monthly Earnings | You may insure 60% of the first $10,000 of your monthly earnings. (And your spouse may insure his/her earnings) | | |
| Maximum Monthly Benefit | Choose $1,000 to $6,000 (in increments of $100) | | |
| Benefit Duration | 2 years | 5 years | to age 65 |
| Waiting Period | You choose: 60, 90 or 180 days. | | |
| Waiver of Premium | Yes, after benefits are payable for 6 months. | | |
| 24-Hour Coverage | Yes, on and off the job. | | |

*Disability benefits received from coverage paid for by the insured are normally TAX-FREE.*
Consult your tax advisor for specific details.

### STEP II: Select a Waiting Period and Find Your Monthly Rate.

**Monthly Rates Per Person Per $100 Monthly Benefit Amount**

**PLAN I – 2 Year Benefit Period**

| Attained Age | Waiting Period | | |
|---|---|---|---|
| | 60 Days | 90 Days | 180 Days |
| Under 35 | .30 | .25 | .22 |
| 35-39 | .42 | .35 | .31 |
| 40-44 | .50 | .42 | .37 |
| 45-49 | .85 | .71 | .63 |
| 50-54 | 1.38 | 1.15 | 1.02 |
| 55-59 | 2.54 | 2.11 | 1.86 |
| 60-64 | 4.02 | 3.34 | 2.96 |
| 65-69 | 6.61 | 5.49 | 4.86 |

**PLAN II – 5 Year Benefit Period**

| Attained Age | Waiting Period | | |
|---|---|---|---|
| | 60 Days | 90 Days | 180 Days |
| Under 35 | .44 | .36 | .32 |
| 35-39 | .63 | .53 | .46 |
| 40-44 | .80 | .67 | .59 |
| 45-49 | 1.41 | 1.17 | 1.04 |
| 50-54 | 2.34 | 1.95 | 1.72 |
| 55-59 | 4.44 | 3.69 | 3.27 |
| 60-69 | 6.61 | 5.49 | 4.86 |

**PLAN III – To Age 65 Benefit Period**

| Attained Age | Waiting Period | | |
|---|---|---|---|
| | 60 Days | 90 Days | 180 Days |
| Under 35 | .79 | .65 | .59 |
| 35-39 | 1.16 | .97 | .85 |
| 40-44 | 1.44 | 1.21 | 1.06 |
| 45-49 | 2.46 | 2.05 | 1.81 |
| 50-54 | 3.62 | 3.01 | 2.66 |
| 55-59 | 5.30 | 4.41 | 3.90 |
| 60-69 | 6.61 | 5.49 | 4.86 |

Rates increase as you move from one age group to the next. Rates may be changed on a class basis.

### How to Calculate Your Premium

Multiply your gross monthly earnings (up to $10,000) by 60% and round down to the nearest $100. This is your maximum insured monthly benefit. Your insured monthly benefit can be any amount from $1,000 to $6,000, in increments of $100, up to your maximum insured monthly benefit. Rates are based on (1) each $100 of insured monthly benefit and (2) your attained age.

**Here's an example:**

A 35-year old member with gross monthly earnings of $3,040 chooses PLAN 1 and a 60-Day Waiting Period.

1. Multiply $3,040 by 60%, which equals $1,824 and round down to the nearest $100 to get a maximum insured monthly benefit of $1,800.
2. In the rate chart, look up the PLAN I rate for age 35 under the 60-Day Waiting Period column. The rate for a $100 insured monthly benefit is $.42.
3. To find the monthly premium, simply divide the desired maximum insured monthly benefit ($1,800) by $100. Then multiply this number by the rate from the table ($.42).

**From our example:**

$3,044 X 60% = $1,824.
Round down to the nearest $100 = $1,800.
$1,800 ÷ $100 = 18
18 X $.42 = $7.56, which is the monthly premium.

Calculate spouse's premium using the same procedure.

### Select Your Billing Period and Payment Method

- Choose **annual, semi-annual, quarterly or monthly billing**. Multiply your calculated monthly premium by 12 for annual billing, 6 for semi-annual billing, or 3 for quarterly billing.
- If you choose **Direct Bill**, a $2.50 per billing period administration fee will be added to your premium. **When you apply, please enclose a check for the total amount.**
- Choose either **Auto-Pay or Direct Bill**…whichever is more convenient for you. If you choose **Auto-Pay**, your premium plus a $1.00 per billing period administration fee will automatically be deducted on time from your bank account. **No extra checks** to write…**no due dates** to remember.

## Step III: Complete This Application for Insurance

Hartford Life Insurance Company
Hartford, Connecticut

**Personal Group Disability Income Protection Plan For State IIA Association Members**

*Please Print* *Use Dark Ink* *Do Not Erase* *Initial All Changes*

| Policyholder: Trustees of Association Trust | Policy #: AGP-5307 | Certificate #: (*Leave Blank*) |
|---|---|---|

| Applicant's Name: (First, Middle Initial, Last) | [ ] Male [ ] Female | Height: _____ft. _____in Weight: _______lb. | Name of Company: |
|---|---|---|---|
| Address: Street: | City: | State: | Zip: |
| Phone Number: (Daytime) | Date of Birth: | Age Last Birthday: | Place of Birth: (Town, State) |
| Home Phone: | FAX: | | Email: |

### IF SPOUSE COVERAGE IS DESIRED, PLEASE COMPLETE THE FOLLOWING:

| Spouses Name: (First, Middle Initial, Last) | [ ] Male [ ] Female | Height: _____ft. _____in Weight: _______lb. | Name of Company: |
|---|---|---|---|
| Address: Street: | City: | State: | Zip: |
| Phone Number: (Daytime) | Date of Birth: | Age Last Birthday: | Place of Birth: (Town, State) |
| Business Telephone: | Email: | | |

Has anyone proposed for coverage been actively engaged in the full-time duties of his or her own occupation during the 30 day period immediately before the date of this application? You: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company?
❑ Yes ❑ No If yes, give details:

| COVERAGE REQUESTED: | ❑ New Coverage | ❑ Change in Coverage | |
|---|---|---|---|
| Monthly Benefit Amount: | Applicant $__________ | Spouse $__________ | |
| Payment Period Option: | ❑ Plan I | ❑ Plan II | ❑ Plan III |
| Waiting Period Option: | ❑ 60 days | ❑ 90 days | ❑ 180 days |

Applicant's Beneficiary:
Print Full Name:______________________________ Relationship: ______________________

Spouse's Beneficiary:
Print Full Name:______________________________ Relationship: ______________________

Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Basic Monthly Pay minus any Other Income Benefits?
You: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

### PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS ON REVERSE SIDE:

1. Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for:
   - (A) a heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system; ❑ Yes ❑ No
   - (B) asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system; ❑ Yes ❑ No
   - (C) colitis, ulcer, kidney disease, or any disease or disorder of the digestive, urinary or reproductive system; ❑ Yes ❑ No
   - (D) alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders; ❑ Yes ❑ No
   - (E) cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands; ❑ Yes ❑ No
   - (F) arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders; ❑ Yes ❑ No
   - (G) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)* or any other immune deficiency disorder? ❑ Yes ❑ No

* "AIDS Related Complex (ARC)" is a condition with signs and symptoms that may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Graves's Disease, rheumatoid arthritis, primary biliary cirrhosis and others.

2. During the past 5 years has anyone proposed for coverage consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this application; or been confined or treated in any hospital, sanitorium or similar institution? ❑ Yes ❑ No

3. Is anyone proposed for coverage now pregnant? ❑ Yes ❑ No
   If yes, Name: When is the baby due?
   Are there any complications?

*continue on second page...*

## IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS (1 TO 3 ON REVERSE SIDE), PLEASE EXPLAIN THE DETAILS:

| Question # | Name | Disorder or Reason | Dates To/From | Give details for any "yes" answer. Explain nature of illness, number of attacks, duration, severity, treatment, names & addresses of physicians, hospitals, & date of full recovery. |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

*(Attach sheet of paper if additional space is needed)*

## AUTHORIZATION:

I hereby certify that I have read or have had read to me all statements and answers in this application, and in any other application or medical form required by the Company, and that they are full, complete, and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk. I understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs. Subject to the deferred effective date provision I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; consumer reporting agency; Medical Information Bureau, Inc.; or employer; to give Hartford Life Insurance Company or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status. Hartford Life Insurance Company will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to the Hartford Life Insurance Company.

I authorize the Hartford Life Insurance Company to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I may apply for Life or Health Insurance, or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application or as required by law. I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my coverage or, if no coverage has been issued one (1) year from the date of this application.

I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request. I certify that I have received the Notice of Insurance Information Practices and the Investigative Consumer Report Pre-Notification.

I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until two (2) years after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation. I further understand that any condition excluded or limited by the policy or by a Health Waiver attached to my certificate will not be covered under this policy at any time.

X ______________________________ ______________
Signature of Applicant Date

X ______________________________ ______________
Signature of Spouse Date

Form SRP-1311 AP (A) (HL) (5066) (CW)

## STEP IV: PLEASE INDICATE YOUR PAYMENT METHOD AND CHOOSE YOUR BILLING PERIOD

### SELECT ONE OF THE FOLLOWING PAYMENT METHODS :

❑ I wish to use Auto-Pay. I hereby authorize Kelsey National Corporation to automatically deduct my premiums from my bank account. I have enclosed a voided check from the account I want the draft to be taken from.

*(We will deduct your premium the first week of the month for that coverage month. You will not receive a billing statement if you choose this option. An administrative fee of $1.00 per billing period will be included.)*

❑ Please bill me directly. My check is enclosed in the amount of $_____________, payable to Kelsey National Corporation.

*(An administrative fee of $2.50 per billing period will be included.)*

### PLEASE CHOOSE YOUR BILLING PERIOD:

❑ Annual ❑ Semi-annual ❑ Quarterly ❑ Monthly

X ______________________________ ______________
Signature Date

IIADIHL-0903

# Here are other benefits, provisions, and definitions you'll want to know about.

### Cost of Living Adjustment (COLA)

After the Waiting Period and one complete calendar year of Total Disability, your net monthly benefit is **increased by 3%**. Benefit increases will be made each year on January 1st for a maximum of five increases.

### Benefits for Part of a Month

To determine the benefits to be paid for a period of less than a full month, divide the benefit by 30 and multiply the result by the number of days in such period.

### Limited Monthly Benefits for Mental/Nervous and Drug/Alcohol

If Total Disability is due to Mental or Nervous Disorders, alcoholism or drug abuse, the Maximum Payment Period will be reduced to 2 years during the insured's lifetime, unless he or she is confined in a hospital or other institution licensed to provide care and treatment for that disability.

### Limited Monthly Benefit for Pre-existing Conditions

A Pre-existing Condition is any condition (diagnosed or undiagnosed) for which you received medical care or treatment within 12 months before becoming insured by this plan.

If Total Disability is due to a pre-existing condition which begins within the first two years of your coverage, no benefits will be paid, unless you have been without medical care or treatment for the condition for 12 consecutive months, ending on or after your effective date of coverage.

### Other Income Benefits

Your monthly income benefit is reduced by...

1. Any Other Income Benefit available from any government programs (Social Security, Workers' Compensation, etc.) and
2. Any benefits available from other group disability and retirement plans or any other income from employment including commissions actually paid to the covered person (unless deferred until later). **The benefit reduction does not apply to individual policies**

...so that the total income from such sources does not exceed 75% of your pre-disability Basic Monthly Earnings.

**If:** the monthly benefit to be paid under this plan, before reduction, plus the other income benefits equals 75% or less of your Basic Monthly Earnings,

**Then:** no reduction will be made under this plan.

**If:** the monthly benefit to be paid under this plan, before reductions, plus the other income benefits exceeds 75% of your Basic Monthly Earnings,

**Then:** a reduction will be made, but will be limited to the amount by which the total income benefit exceeds 75%.

### When Benefits End

All benefits will end on the date: (1) the member fails to give required proof of continuing Total Disability, (2) the Total Disability ends, (3) the maximum benefit period ends, or (4) the member dies. If the group policy ends, this will not act to end the maximum benefit period.

### Exclusions

Benefits are not paid for losses due to: intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane; pregnancy or childbirth, except Complications of Pregnancy; war or act of war, whether declared or not; any Injury sustained while riding on, boarding or alighting from, any aircraft: a) as a pilot, crew member or student pilot; b) operated by any military authority (land, sea or air), unless it is a Military Transport Aircraft used for transport and operated by the United States Military Air Mobility Command (AMC) or an AMC type service of a national government recognized by the United States; or c) being used for tests, experimental purposes, stunt flying, racing or endurance tests; the commission or attempted commission of a felony by You; Sickness contracted or Injury sustained while on full-time active duty as a member of the Armed Forces (land, water, air) of any country or international authority.

### Termination of Coverage

Your coverage can only be cancelled if (1) you are no longer an association member, (2) premiums are not paid, (3) age 70 is attained, (4) the insured ceases to be actively at work (except by reason of disability covered by this plan), or (5) the group policy ends. Spouse's coverage terminates when the member's coverage terminates.

### Surviving Spouse Continuation

If the covered member dies while his or her spouse is covered under this policy, the spouse can continue his or her coverage by making a request to the company and paying the premium within 31 days of the member's death.

### Evidence of Insurability

A medical application with MIB authorization is required for all monthly benefit amounts and benefit periods. Depending on your age, the amount of coverage you request, and your answers on your application, a medical examination, medical test(s) or other evidence of good health may be required. Any exams/test requested will be conducted at your convenience and at no expense to you.

### DEFINITIONS

**Total Disability** means: during the Waiting Period and next 24 months, the member's complete inability to perform the material duties of his regular (the job he was performing on the day before Total Disability began); after such 24 months, the member's complete inability to perform the material duties of any gainful job for which he is reasonably fit by training, education or experience.

The Total Disability must be the result of an injury or sickness. To be considered Totally Disabled, the member must also be under the regular care of a physician who is not a family member.

**Basic Monthly Earnings** means the member's monthly rate of pay from his employee or self-employment. Such rate will be that in effect on the day before Total Disability begins. Basic Monthly Earnings includes commissions - but not bonuses, overtime pay, or other extra compensation. Commissions will be averaged for the lesser of: the 24 month period of employment before the date Total Disability begins or the period of employment.

**Waiting Period** means a period of consecutive days of Total Disability for which no benefit is payable.

**Actively-at-Work**: means you are performing all regular duties of an occupation for wage or profit on a full-time basis (at least 30 hours per week). You are considered Actively at Work for holiday or vacation absences of three weeks or less.

### NOTICE OF INSURANCE INFORMATION PRACTICES

Your application is our major source of information. However, Hartford Life Insurance Company may also collect or verify information by contacting individuals or organizations which have information or records about you or others to be insured.

Information regarding your insurability will be treated as confidential. Such information will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business. Hartford Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt from you, the Bureau will arrange disclosure of any information it may have in your file. Medical information will be disclosed only to your attending physician. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112; telephone number (617) 426-3660.

Hartford Life Insurance Company or its reinsurer(s) may also release information in your file to other insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted.

Upon written request , Hartford Life Insurance Company will provide you with information in you file. Medical information will be disclosed only through a physician you designate. Details regarding your right to correct or amend information in your file will be furnished upon written request.

If you would like further details, contact Hartford Life Insurance Company, P.O. Box 2999, Hartford, CT 06104-2999, Attn: Group Benefits Department.

This brochure explains the general purposes of the insurance program, but in no way changes or affects the policy as actually issued. In the event of any discrepancy between the brochure and the contract, the terms of the contract apply. Complete details are in the certificate of insurance issued to each insured individual. Benefit may not be available in all states. Policy Form # SRP-1311A (5307)

The Hartford[1] is one of the largest life and disability insurance groups in the U.S. Their investment portfolio is of the highest quality, and their financial returns continue to earn strong stable ratings in the industry[2]. Hartford is rated A+ by A.M. Best, an independent industry analyst. Along with a reputation for rock solid financial stability, this carrier has become known for its innovation in developing services and benefits for today's insurance climate.

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing company Hartford Life Insurance Company.

[2] Based on ratings as of 5/31/03. A+ is the second highest of 15 A.M. Best categories.

**Administered by:**

Kelsey National Corporation
3030 S. Bundy Drive
Los Angeles, CA 90066
PH: (800) 366-5656
FAX: (310) 390-3158
nk@kelsey.com

Kelsey National Corporation

**Underwritten by:**

Hartford Life Insurance Company
Hartford, CT 06115