Society of Diagnostic Medical Sonography

# DISABILITY INCOME INSURANCE APPLICATION

Hartford Life Insurance Company

## APPLICANT INFORMATION

Name: ______________________________ Sex: ❏ Male ❏ Female

Address: ______________________________

City: ______________________________ State: ______ Zip Code: __________

Phone # ______________________________ Email: ______________________________

Birthdate ____ /_____ /________ Place of Birth (Town, State) ______________________________

Height _____ ft _____in________________ Weight ______lb. Occupation ______________________________

## COVERAGE REQUESTED

Select your monthly benefit: $_________ (in $100 increments - $500 minimum, $2,500 maximum)

Waiting Period: ❏ 60 days ❏ 90 days ❏ 180 days

## ELIGIBILITY

To be eligible for coverage, you must have been actively engaged in the full-time duties of your occupation during the 180 day period immediately before the date of this application. **This offer is limited to those members under age 65, not already insured by this plan, who can accurately answer "NO" to the questions below:**

1. In the last five (5) years have you had or been treated for cancer, tumor, high blood pressure, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any lung or respiratory disorder, kidney or genitourinary disorder, alcohol or drug dependency, mental or nervous disorder, or bone, joint, back, muscle or connective tissue disorder? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ❏ Yes ❏ No
2. Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ❏ Yes ❏ No
3. Have you been hospitalized in the last 12 months (excluding maternity with complete recovery)? . . . . . . . ❏ Yes ❏ No

## AUTHORIZATION

I hereby certify that all statements and answers in this application, are full, complete, and true to the best of my knowledge and belief. 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. I further understand that any condition excluded or limited by the policy will not be covered under this policy at any time.

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 24 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or I have not incurred charges, received treatment, or consulted a physician or taken prescription drugs for such condition for 12 continuous months, provided that the condition is not specifically excluded or limited by the policy.

X ______________________________ ______________________________

Signature of Member Date

Underwritten by Hartford Life Insurance Company

**PLEASE SEND NO MONEY NOW; YOU WILL BE BILLED LATER, AFTER YOUR APPLICATION IS APPROVED.**

## PAYMENT OPTIONS

**1.Select your premium payment schedule:** ❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

**2.Then select one of the following:**

❑ **Automatic deduction of your premium from your bank account. Please complete the bank information OR attach a voided check** from the bank account that you wish the draft to be taken from. Either way, **sign and date below**. 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. ($2.00 per bill)

❑ Please send me a premium billing statement. ($2.50 per billing statement)

**BANK DRAFT AUTHORIZATION**

**I HEREBY AUTHORIZE** Kelsey National Corporation and/or any entity acting on its behalf to initiate payment from my depository financial institution account and I authorize my depository financial institution to honor those payments. This authorization is to remain in full force and effect until Kelsey National Corporation has received written notification from me of its termination in such time and in such manner as to afford Kelsey National Corporation and my financial institution a reasonable opportunity to act on it.

Name of Financial Institution ______________________

Routing # ______________________

(First 9 digits on bottom left of check or deposit slip)

Account# ______________________

(14 digits, including all zeros, found next to routing number)

Signature: ______________________

Date: ______________________

Check or Deposit Slip

John and Jane Doe
2345 JD Road
West Anywhere, JD 23456

9999

Date ________

Pay to the Order of ______________________ $ ____

______________________ Dollars

First National Bank of Banks
1234 Banking Way
Easy Town, BT, 12345

For ____________

⑆123456789⑆ 123⑈12345⑈1 ⑈ 9999

Transit Routing Number Account Number Check Number

## STATE NOTICE

Any person who includes any false or misleading information on an application or filing a claim for an insurance policy is subject to criminal and civil penalties. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, 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 defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If while in the state of Florida, a person knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, the person is guilty of a felony in the third degree. 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, misleading or Deceptive 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 be subject to substantial civil and/or criminal penalty where and to the extent allowed by state law.

## 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 within 15 days. 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 1-866-692-6901 (TTY 866-346-3642 for hearing impaired).

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 your 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 Division.

**After completing both sides, please sign and mail to:** Hartford Disability Application Processing
Kelsey National Corporation
3030 South Bundy Drive
Los Angeles, CA 90066

**Or, Fax both sides to: (310) 397-2934**
**Questions? Please call (800) 366-5656 x504**

**MONTHLY COVERAGE:** You may purchase a monthly coverage amount of $500 to $2,500 (in increments of $100). *Please note: Your benefit amount is limited to 60% of your Basic Monthly Pay. Benefits will be reduced by the amount of other income benefits you receive and by 50% of income derived from approved rehabilitation programs, but in no event will your benefit be less than $50 per month. You'll find a list of other income benefits later in this brochure.

**BENEFIT PERIODS:** All monthly benefits are payable for a maximum of two years per Period of Disability.

**WAITING PERIODS:** Benefits begin after you have been Totally Disabled for 60, 90 or 180 days.

**WHO'S ELIGIBLE?** As a member of SDMS, you're eligible to apply for coverage. To be eligible, applicants must be under age 65, work at least 30 hours a week for the six consecutive months preceding your effective date of coverage, and be a resident of the United States.

**WHAT'S COVERED?** This plan covers disabilities due to covered 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.

**WHAT IS A TOTAL DISABILITY?** You'll receive own-occupation protection for up to 2 years, which means you qualify for benefits if you cannot perform the substantial and material duties of your own regular occupation. Thereafter, the definition of disability is the continuous inability to perform any occupation for which you are reasonably suited in terms of education, training and experience.

**WHAT IF YOU RETURN TO WORK AFTER A DISABILITY, BUT SUFFER A RELAPSE?** Since disabilities don't always start and stop in easily defined time frames, we've developed a plan that is flexible enough to accommodate various disability durations and scenarios. If you return to work for fewer than 15 days 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. This provision relieves you of having to start the entire waiting period again.

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 (at least 30 hours per week), are considered a single period of disability. This means you won't have to satisfy a new waiting period before qualifying for benefits should you suffer a relapse upon returning to active employment after receiving benefits for a disability.

**WILL MY BENEFITS BE REDUCED BY OTHER DISABILITY BENEFITS THAT I MIGHT RECEIVE?** The actual benefit you receive at the time of your claim may be different, depending upon your income, offsets for other income benefits and other variables.

Other income means the amount of any benefit for loss of income that you or your family receive or are eligible to receive from Social Security Disability Income or similar plans; Workers' compensation or occupational disease laws, or similar laws; group, association, union or other organizational coverage; employer-related individual policies; governmental laws or programs that provide disability or unemployment benefits as a result of your job with any employer; disability coverage under any employer's retirement plan; damages or settlements for income loss; and no-fault automobile insurance plans. Other income benefits also include retirement benefits from retirement plans that are wholly or partially funded by employer contributions, unless you were receiving them prior to becoming disabled or you immediately transfer the payments to another plan qualified by the U.S. Internal Revenue Service for the funding of a future retirement.

Finally, other income benefits include retirement benefits you or your family receive from Social Security or similar plans, unless you were receiving them prior to becoming disabled.

**IS THERE ANY WAIVER OF PREMIUM PROVISION?** Yes - Future premiums will be waived for as long as benefits are payable after you have been disabled for six months.

**EXCLUSIONS:** This Policy does not cover: 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.

**PRE-EXISTING CONDITION LIMITATION:** Any period of disability beginning within the first twelve months of your coverage which is due to a Pre-Existing condition will not be covered. This will not apply to periods of disability beginning after you have been without medical care for the condition for 12 consecutive months ending on or after your effective date of coverage. A Pre-Existing Condition is any condition (diagnosed or undiagnosed) for which you received medical care or treatment within the 12-month period preceding the effective date of your insurance.

**CAN MY COVERAGE BE CANCELED?**
Your coverage can only be canceled if:

a) you are no longer a SDMS member;
b) you do not pay your premiums;
c) you cease to be actively at work (except by reason of disability covered by this plan); or
d) the Master Policy is no longer in force.

**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 Hartford, 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 postponed until you are actively at work for 90 consecutive days.

Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s), or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience and at no expense to you.

**BASIC MONTHLY PAY:** With respect to a member who is self-employed, Basic Monthly Pay means your average net monthly income (gross revenues less business expenses) from the personal practice of your profession or personal conduct of your main business. The average is based on net income for the twelve months or 24 months, whichever produces the higher average, before the determination is made. If you have been self-employed for less than 12 months, it is based on the whole time you were self-employed. If your practice is incorporated, earned income includes the cost to your company of fringe benefits and your share of total surplus. Income does not include investment returns, rents, royalties, and the like income, which is not directly produced from your current work.

With respect to a member who is not self-employed, Basic Monthly Pay means your average monthly rate of pay, but not counting bonuses, overtime pay or any other fringe benefit or extra compensation. The average is based on monthly pay for the twelve months or twenty- four months, whichever produces the higher average, before determination is made.

**OFFSET PROVISION:** The benefit amount payable as the result of the Insured Person's Total Disability will be the lesser of:

a) the Monthly Benefit Amount; or
b) 60% of the Insured Person's Basic Monthly Pay minus:
1) any Other Income Benefits, including those for which the Insured Person could collect but did not apply; and
2) all other income from any employer or for any work.

However, if the Insured Person's Monthly Benefit Amount would reduce to less than $50.00 per month due to Other Income Benefits, then the minimum Monthly Benefit Amount under this benefit will be $50.00 per month.

## WHAT ARE THE MONTHLY RATES FOR THIS COVERAGE?

You may apply for monthly coverage in $100 increments from $500 up to $2,500 a month. See the Monthly Benefit Worksheet to calculate the amount of disability income insurance you're eligible to purchase.

| 2 Year Maximum Benefit Period | | | |
|---|---|---|---|
| Attained Age | Waiting Periods | | |
| | 60 Days | 90 Days | 180 Days |
| Less than 30 | $1.20 | $0.85 | $0.70 |
| 30-39 | $1.45 | $1.00 | $0.85 |
| 40-49 | $2.30 | $1.60 | $1.35 |
| 50-54 | $3.60 | $2.75 | $1.80 |
| 55-59 | $5.35 | $4.40 | $2.65 |
| 60-64 | $8.35 | $6.75 | $4.90 |

Rates and/or benefits may be changed on a class basis. Rates are based on the attained age of the Insured Person and increase as you enter each new age category.

**PLEASE SEND NO MONEY NOW; YOU WILL BE BILLED LATER, AFTER YOUR APPLICATION IS APPROVED.**

## MONTHLY COVERAGE WORKSHEET

**Coverage Calculation:** Here's how to calculate the amount of disability income insurance you're eligible to purchase through the SDMS Disability Income Plan given your current income and existing disability benefits. The actual benefit you receive at time of claim may be different, depending upon your income, offsets for other income benefits and other variables. Benefits will be affected by Social Security and Workers' Compensation.

1. **Monthly Income**
   Your average monthly earned income for the past 12 months before taxes including salary, fees and commissions (sole practitioners subtract business expenses from gross monthly income) . . . . . . . . . . ____________

2. **Multiply**
   Multiply the total from line 1 by your monthly benefit percentage of [.60] . . . . . . . . . . . . . . . . . . . . . . ________X .60

   This is your “Total” for Line 2 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . (=) __________

3. **Offsets**
   Add together any other monthly income benefits you have. Examples include, but are not limited to, employer sponsored individual disability plans, and group disability or group pension plans, including any current coverage through SDMS . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . (-) __________

4. **Subtotal**
   Subtract the amount on line 3 from the amount on line 2 . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . (=) __________

5. **Your Total Monthly Benefit**
   Round the total from line 4 down to the nearest $100. This is the Maximum monthly disability income benefit for which you can Apply (maximum benefit is $2,500) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ____________

**Rate Calculation:** Rates are based on your current age and will change when you reach the next age bracket.

6. Divide your monthly benefit (line 5) by [$100] . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ____________

7. From the base rates included on this application, determine the appropriate rate per [$100] of monthly disability benefit . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . (x) __________

8. Multiply the benefit factor on line 6 by the rate on line 7.

**THIS IS YOUR MONTHLY PREMIUM** (=) __________

Underwritten by Hartford Life Insurance Company, Simsbury, CT

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

This brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Hartford Life Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder. This program may vary and may not be available to residents of all states.