

Group Term Life Insurance Plan

for Members of the American String Teachers Association

Special Offer

Planning ahead often spells the difference between success and failure. When it comes to your family's security, that means adequate life insurance protection. Now is a good time to review your life insurance protection to make sure it has kept pace with inflation and your changing needs.

Take advantage of this excellent program for yourself and your family. Benefits and enrollment procedures are provided in this brochure.

Coverage Effective Date

Your insurance will become effective on the first day of the month following the date that the Company approved your application and your premium is paid.

Dependents' coverage begins the date you become covered or the first day of the month following approval to add such dependent, whichever date is later, and provided the required premium is paid.

On the date the insurance is to become effective, you must be actively-at-work*; or if not employed, able to carry on all the normal and customary activities of a person of like age and sex in good health. Otherwise you will not be covered until the earlier of: the first day of the month on or next following the date you complete 90 consecutive days of full-time active employment; or the first day of the month on or next following the date you have been able, for 90 consecutive days, to carry on all the normal and customary activities of a person of like age and sex in good health.

*Actively-at-work means a person who is performing all the regular duties of his or her occupation on a full-time basis (at least 30 hours per week) at his or her customary place of employment.

Premiums

Premiums are based on each person's age and tobacco use status at the date of issue and change on the renewal dates (occurring as each insured attains ages 30, 35, 40, 45, 50, 55, 60 and 65). The table below details premiums for amounts of coverage above \$100,000 based on non-tobacco user rates. Rates for tobacco users and for amounts of coverage of \$100,000 or less are available from INSURANCE SPECIALISTS, INC. upon request.

You are considered a non-tobacco user if you have not smoked cigarettes, cigars or used a pipe or chewing tobacco, nicotine chewing gum or snuff during the 12 months before submitting an application for insurance.

Benefits

Members and member spouses may apply for benefits ranging from \$10,000 to \$500,000 (in \$10,000 increments). Also, all children between 15 days and six months of age may be covered for \$100; between six months and 19 years of age (to age 25 if a full-time student in a school, college or university), coverage is available for dependent children for a full \$5,000.

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.

The life benefit will be paid for death occurring at any time, any place, from any cause, except suicide during the first two years (we will refund the entire premium paid to date if suicide is committed during the first two years). Life benefits are paid to the beneficiary you designate.

Eligibility

All Association members in good standing under age 60, who reside in the United States, and who can provide acceptable evidence of insurability, are eligible to apply for coverage. All spouses of members are eligible for coverage if he/she meets the above guidelines and is not legally separated or divorced from you. Unmarried, dependent children of members for whom they provide support, from 15 days to 19 years of age (to age 25 if a full-time student), are eligible for coverage as well.

When both spouses are eligible members, each may apply for coverage as "members"; however, coverage may not be duplicated by applying as dependents of each other. Coverage for eligible children may only be requested by one member.

Conversion Privilege

If your coverage ends for any reason (unless the policy is canceled, coverage for a class of persons ends, or because of non-payment), you have the right to request an individual policy without having to provide evidence of insurability. To convert to an individual policy you must complete a notice of conversion privilege form for the conversion policy and send in the required premium within 31 days from the time your term life plan ends. Complete details may be found in your term life Certificate of Insurance.

Quarterly Non-Tobacco User Premiums for Amounts of Coverage Greater than \$100,000

Attained Age	200,000 of Coverage		300,000 of Coverage		400,000 of Coverage		500,000 of Coverage	
	Male	Female	Male	Female	Male	Female	Male	Female
20-24	\$36.00	\$18.00	\$54.00	\$27.00	\$72.00	\$36.00	\$90.00	\$45.00
25-29	\$36.00	\$18.00	\$54.00	\$27.00	\$72.00	\$36.00	\$90.00	\$45.00
30-34	\$36.00	\$24.00	\$54.00	\$36.00	\$72.00	\$48.00	\$90.00	\$60.00
35-39	\$42.00	\$30.00	\$63.00	\$45.00	\$84.00	\$60.00	\$105.00	\$75.00
40-44	\$66.00	\$48.00	\$99.00	\$72.00	\$132.00	\$96.00	\$165.00	\$120.00
45-49	\$114.00	\$72.00	\$171.00	\$108.00	\$228.00	\$144.00	\$285.00	\$180.00
50-54	\$204.00	\$114.00	\$306.00	\$171.00	\$408.00	\$228.00	\$510.00	\$285.00
55-59	\$342.00	\$180.00	\$513.00	\$270.00	\$684.00	\$360.00	\$855.00	\$450.00
60-64*	\$546.00	\$282.00	\$819.00	\$423.00	\$1,092.00	\$564.00	\$1,365.00	\$705.00
65-69*	\$834.00	\$456.00	\$1,251.00	\$684.00	\$1,668.00	\$912.00	\$2,085.00	\$1,140.00
70*	\$1,086.00	\$606.00	\$1,629.00	\$909.00	\$2,172.00	\$1,212.00	\$2,715.00	\$1,515.00

One or more children: \$4.50 Quarterly (Benefit under 6 months of age - \$100; 6 months or older - \$5,000)

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

*Renewal Only

30 Day Free Review

You have 30 days from your effective date of coverage to look over the program and discuss it with your family and advisors. If you are not satisfied, you may return your certificate within 30 days for a full premium refund (less any claims paid).

Beneficiary Designation

Your beneficiary is the person(s) last designated by you in writing and recorded on behalf of The Hartford. You are the automatic beneficiary of your dependents' insurance under the Plan. The eligible Member and spouse may name anyone they choose as the beneficiary for the coverage on their life. The primary insured is the automatic beneficiary of any covered children. You can change your beneficiary at any time by giving written notice to INSURANCE SPECIALISTS, INC.

If no beneficiary designation has been made, benefits will be paid as outlined in the Certificate of Insurance issued to each insured person.

Exclusions and Limitations

Suicide is excluded for two years from the effective date of each person's coverage. In the case of suicide within the first two years of coverage, benefits will be limited to the refund of premiums.

How Do I Apply?

1. Complete the enclosed application and answer all questions in full. Sign your name and date the Application. Your Application is subject to approval by The Hartford.
2. Mail your completed application to:
ISI ADMINISTRATIVE CENTER - SALES
PO Box 2327
Beaufort, SC 29901
3. Don't send any money now; you will be billed once your application is approved. When your application is approved, you'll receive your Certificate of Insurance. If you have any questions, feel free to call the INSURANCE SPECIALISTS, INC. at this toll-free ISI DIRECT number: 1-888-ISI-1959.

Notice of Insurance Information Practices

Your application is our major source of information. However, The Hartford 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. The Hartford 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 1-866-346-3642 for hearing impaired).

The Hartford 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, The Hartford 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:
The Hartford
P.O. Box 2999
Hartford, CT 06104-2999
Attn. Group Benefits Department

Notice of Policy Cancellation

This Policy may be cancelled at any time by 60 days written notice. If the policy is cancelled, your unearned premium will be promptly returned to you on a prorated basis.

Benefit Reductions

The amount of insurance applicable to each eligible person or spouse will be reduced to the lesser of \$50,000 or 50% on the premium due date on or next following the date he or she attains age 65, with an appropriate reduction in premium.

Any change in the amounts of insurance due to an increase in an insured person's age will become effective on the premium due date occurring on or next following the date of the increase in such a person's age.

Termination

Your coverage will remain in force as long as you pay your premiums when due, remain an active Association member, you are under age 70, the Association participates and the master policy remains in force. Dependents' coverage terminates if your coverage terminates, premiums are not paid when due or such person ceases to be an eligible dependent. Coverage ends at age 70.

This brochure explains the general purpose of the insurance described, but in no way changes or affects the Master Policy AGL-1638 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 the Hartford Life and Accident 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. Policy Form # SRP-1153 A (HLA) (1638)

Underwritten By:

Hartford Life and Accident Insurance Company
Hartford, CT • 06104-2999



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CODB

Application Form for Group Term Life Insurance

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

ISI Insurance Trust Policy Number AGL-1638

Policyholder Name ISI INSURANCE TRUST	Name of Association AMERICAN STRING TEACHERS ASSOCIATION
Member's Name (First, Middle, Last)	

Applicant Category

Please submit one application form per applicant. Copies of this form with original signatures are acceptable.

Member Member Spouse

Applicant Information

Name (First, Middle, Last)		Occupation		
Date of Birth	Place of Birth (City, State)	Weight (lbs.)	Height (ft., in.)	Sex
Address (Street, City, State, Zip Code)		Phone Number	E-mail Address	

Desired Amount of Coverage

Members and member spouses may apply for amounts of coverage from \$10,000 to \$500,000 (in \$10,000 increments). All children between 15 days and six months of age may be covered for \$100; between six months and 19 years of age (to age 25 if a full-time student in a school, college or university), coverage is available for dependent children for a full \$5,000. A spouse may not be covered under a plan with benefits greater than the member's plan. If request is to change existing coverage, print only the additional amount desired.

\$200,000 \$300,000 \$400,000 \$500,000 Other: _____
 Child Coverage Desired (\$5,000 per child)

Please Indicate if Request is for: New Coverage Change in Coverage

Billing Mode

Quarterly Semi-annually Annually

Tobacco Use

At any time during the past 12 months to the present, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff? Yes No

Beneficiary

The proposed insured will be the beneficiary for any dependent coverage desired.

Name (First, Middle, Last)	Relationship to proposed Insured
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STATEMENT OF HEALTH (Please initial any changes you make on this form.)

Please complete the following (If you answer "Yes" to question 2 or 3, please explain the details below.)		Yes	No
1	In the last 2 years, have you or your Spouse been unable to perform the full-time duties of your occupation for 10 consecutive days, or if not employed, been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90 day period immediately preceding the date of this application for 10 consecutive days?		
2	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?		
B	Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?		
C	Colitis, ulcer, kidney disease or any disease or disorder of the digestive, urinary or reproductive systems?		
D	Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?		
E	Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?		
F	Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?		
G	Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder?		
3	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 have you been confined or treated in any hospital, sanatorium or similar institution?		

If you answered "Yes" to any of the above questions, please give the details below. Attach a sheet of paper if additional space is needed.

Question Number	Name of Family Member	Dates To/From	Give details for any "Yes" answer. Explain nature of illness, number of attacks, duration, severity, treatment, names and addresses of physicians, hospitals, and date of full recovery.

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION Please read carefully all items and sign below.

I hereby certify that I have read all statements and answers in this application, and 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 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 paid my first premium.

I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; Medical Information Bureau, Inc.; or employer; to give Hartford¹ or its legal representative information about my or my dependent's physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status.

The Hartford will use the above information to decide if and to what extent I or my dependents are 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.

I authorize The Hartford to give information about me or my dependents to any other insurance company to whom I or my dependents may apply for Life and Health Insurance, the Medical Information Bureau, Inc., 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 my dependent's 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.

Applicant's Signature <i>Signature and date required to process your application.</i>	Date
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Please check "Yes" or "No" on the next line.

By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? Yes No

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