

Ten Year Level Term Life Insurance Plan for American String Teachers Association Members

Plan Features

The Hartford¹ 10 Year Level Term Life Insurance Plan is designed to meet the insurance needs of Association members who wish to provide financial stability to their loved ones after they are gone.

This coverage offers all of the following and more:

- Level Issue Age premiums for 10 years
- Guaranteed coverage for 10 years
- Guaranteed offer of coverage at the end of 10 years: either reapply for another 10 year term or enroll for annual renewable term life.

Benefits

Members and their spouses may apply for benefits ranging from \$50,000 to \$250,000 (in \$50,000 increments).

Eligibility

All Association members under age 65, 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 the Association member. The policy age limit is 75.

Quarterly Non-Tobacco User Premiums

AGE	\$50,000 of Coverage		\$100,000 of Coverage		\$150,000 of Coverage		\$200,000 of Coverage		\$250,000 of Coverage	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
20-30	\$12.50	\$10.88	\$19.00	\$16.00	\$28.50	\$24.00	\$38.00	\$32.00	\$47.50	\$40.00
31	\$12.88	\$11.38	\$20.00	\$16.75	\$30.00	\$25.13	\$40.00	\$33.50	\$50.00	\$41.88
32	\$13.38	\$11.75	\$20.75	\$17.75	\$31.13	\$26.63	\$41.50	\$35.50	\$51.88	\$44.38
33	\$13.88	\$12.25	\$21.75	\$18.50	\$32.63	\$27.75	\$43.50	\$37.00	\$54.38	\$46.25
34	\$14.38	\$12.63	\$22.75	\$19.50	\$34.13	\$29.25	\$45.50	\$39.00	\$56.88	\$48.75
35	\$15.00	\$13.25	\$24.25	\$20.50	\$36.38	\$30.75	\$48.50	\$41.00	\$60.63	\$51.25
36	\$15.88	\$13.75	\$25.75	\$21.50	\$38.63	\$32.25	\$51.50	\$43.00	\$64.38	\$53.75
37	\$16.75	\$14.25	\$27.50	\$22.75	\$41.25	\$34.13	\$55.00	\$45.50	\$68.75	\$56.88
38	\$17.50	\$15.00	\$29.25	\$24.00	\$43.88	\$36.00	\$58.50	\$48.00	\$73.13	\$60.00
39	\$18.50	\$15.75	\$31.00	\$25.50	\$46.50	\$38.25	\$62.00	\$51.00	\$77.50	\$63.75
40	\$19.38	\$16.50	\$33.00	\$27.00	\$49.50	\$40.50	\$66.00	\$54.00	\$82.50	\$67.50
41	\$20.38	\$17.13	\$35.00	\$28.50	\$52.50	\$42.75	\$70.00	\$57.00	\$87.50	\$71.25
42	\$21.50	\$18.00	\$37.00	\$30.00	\$55.50	\$45.00	\$74.00	\$60.00	\$92.50	\$75.00
43	\$22.75	\$18.63	\$39.50	\$31.25	\$59.25	\$46.88	\$79.00	\$62.50	\$98.75	\$78.13
44	\$24.13	\$19.38	\$42.50	\$32.75	\$63.75	\$49.13	\$85.00	\$65.50	\$106.25	\$81.88
45	\$25.75	\$20.13	\$45.50	\$34.25	\$68.25	\$51.38	\$91.00	\$68.50	\$113.75	\$85.63
46	\$27.38	\$21.00	\$49.00	\$36.00	\$73.50	\$54.00	\$98.00	\$72.00	\$122.50	\$90.00
47	\$29.25	\$21.88	\$52.50	\$37.75	\$78.75	\$56.63	\$105.00	\$75.50	\$131.25	\$94.38
48	\$30.88	\$22.75	\$55.75	\$39.50	\$83.63	\$59.25	\$111.50	\$79.00	\$139.38	\$98.75
49	\$32.38	\$23.75	\$59.00	\$41.50	\$88.50	\$62.25	\$118.00	\$83.00	\$147.50	\$103.75
50	\$34.13	\$24.75	\$62.50	\$43.50	\$93.75	\$65.25	\$125.00	\$87.00	\$156.25	\$108.75
51	\$36.00	\$25.75	\$66.25	\$45.75	\$99.38	\$68.63	\$132.50	\$91.50	\$165.63	\$114.38
52	\$37.88	\$26.88	\$70.00	\$47.75	\$105.00	\$71.63	\$140.00	\$95.50	\$175.00	\$119.38
53	\$40.88	\$28.25	\$75.75	\$50.50	\$113.63	\$75.75	\$151.50	\$101.00	\$189.38	\$126.25
54	\$44.13	\$29.63	\$82.25	\$53.25	\$123.38	\$79.88	\$164.50	\$106.50	\$205.63	\$133.13
55	\$47.63	\$31.13	\$89.25	\$56.50	\$133.88	\$84.75	\$178.50	\$113.00	\$223.13	\$141.25
56	\$51.38	\$29.50	\$96.75	\$59.75	\$145.13	\$89.63	\$193.50	\$119.50	\$241.88	\$149.38
57	\$55.38	\$34.50	\$104.75	\$63.25	\$157.13	\$94.88	\$209.50	\$126.50	\$261.88	\$158.13
58	\$59.25	\$36.38	\$112.50	\$66.75	\$168.75	\$100.13	\$225.00	\$133.50	\$281.25	\$166.88
59	\$63.38	\$38.38	\$121.00	\$70.75	\$181.50	\$106.13	\$242.00	\$141.50	\$302.50	\$176.88
60	\$67.50	\$40.38	\$129.00	\$74.75	\$193.50	\$112.13	\$258.00	\$149.50	\$322.50	\$186.88
61	\$76.50	\$46.00	\$147.00	\$86.00	\$220.50	\$129.00	\$294.00	\$172.00	\$367.50	\$215.00
62	\$86.13	\$51.88	\$166.25	\$98.00	\$249.38	\$147.00	\$332.50	\$196.00	\$415.63	\$245.00
63	\$97.75	\$58.25	\$189.50	\$110.50	\$284.25	\$165.75	\$379.00	\$221.00	\$473.75	\$276.25
64	\$110.75	\$64.38	\$215.50	\$124.50	\$323.25	\$186.75	\$431.00	\$249.00	\$538.75	\$311.25

The rates shown reflect the current rate and benefit structure of the Preferred category for the initial 10 year term. In order to be eligible for these rates, you must be able to meet The Hartford's underwriting standards and be a Non-Tobacco User. If you do meet the Preferred underwriting standards, you may be eligible for coverage at Standard rates; or if you exceed these standards you may be eligible at Super-Preferred rates. Standard and Super-Preferred rates available upon request.

Tobacco User means a Covered Person who has smoked cigarettes, cigars or used a pipe or chewing tobacco, nicotine chewing gum or snuff during the 12 months prior to the date he or she applied for coverage.

See reverse side for additional plan details and how to apply.

Beneficiary Designation

You may name any person(s) to be the beneficiary of this insurance, and your beneficiary may be changed at any time by giving written notice to INSURANCE SPECIALISTS, INC.

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).

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.

Exclusions and Limitations

Suicide, whether sane or insane, is excluded for two years from the effective date of each person's coverage (In the event of death due to suicide, we will only pay an amount equal to the premium paid for coverage to the date of death).

Incontestability

The validity of any amount of your life insurance which has been in force for 2 years during your lifetime will not be contested except for non-payment of premium contributions and provisions related to your eligibility for insurance.

Insurance After the 10 Year Term Ends

After the 10 Year Level Term period expires, you have the option to renew 10 Year Level Term coverage with evidence of insurability. If you opt out of being re-medically underwritten or do not submit satisfactory evidence of insurance, you have the opportunity to enroll in Annual Renewable Term (ART) rates offered in 5 year attained age rate bands. You must be under age 65 to re-enter the 10 Year Term plan or enter the ART plan. Rates and coverage under ART group policy are not guaranteed.

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 Dept.

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. 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.
2. Mail your completed application to:
ISI ADMINISTRATIVE CENTER - SALES
P.O. 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, please feel free to call INSURANCE SPECIALISTS, INC. toll-free at: 1-888-ISI-1959.

Termination

Under the 10 Year Level Term Life policy, coverage will terminate on the earliest of the following dates:

- 1) the premium due date for which premium is not paid within the 31 day grace period; or
- 2) at the end of the 10 year coverage period.

Under the Annual Renewable Term group policy, coverage will terminate on the earliest of the following dates:

- 1) the date the master policy is cancelled;
- 2) the premium due date on or next following the date the insured ceases to be a member of the organization;
- 3) premium due date for which premium is not paid within the 31 day grace period; or
- 4) the premium due date on or next following the date the insured person reaches the policy age limit of 75.

This brochure explains the general purpose of the insurance described, but in no way changes or affects the Master Policy AGT-1013 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 (1013)

Underwritten By:

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



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GROUP TEN YEAR LEVEL TERM ENROLLMENT FORM

Please print in ink or type all answers

Policy # AGT-1013

Name (Last, First, Middle Initial)			Occupation		Name of Organization AMERICAN STRING TEACHERS ASSOCIATION	
Date of Birth (mm/dd/yy)	Weight (lbs)	Height (ft, in)	Sex	E-mail Address	Fax Number	
Home Address (Street, City, State, Zip Code)					Home Phone	
Billing Address (Street, City, State, Zip Code)					Office Phone	

AMOUNT OF COVERAGE DESIRED Choose from 50,000 to \$250,000 in \$50,000 increments. \$

BILLING PERIOD DESIRED: Quarterly Semi-annually Annually

PLEASE INDICATE IF REQUEST IS FOR: New Coverage Change in Coverage

At any time in the past twelve months to the present, has anyone proposed for coverage smoked cigarettes or used a pipe, chewing tobacco, nicotine chewing gum or snuff? Yes No

Is the insurance applied for intended to replace, discontinue or change an existing policy? 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.)

Answer the following questions as they apply to you and all dependents to be insured.		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?		

Please turn over to answer additional questions

If you answered "Yes" to any of the questions on reverse side, 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 The 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 *Sign name in full*

Date

Signature and date required to process your application. A separate application must be completed by each applicant.

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