

# AFSA YOUTH LIFE INSURANCE PLAN APPLICATION

Complete all information in ink.

AGL-1551  
048374010808 01447

## 1 Please complete:

Member Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

AFSA Member No.: \_\_\_\_\_

Telephone #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_  
(Optional. AFSA will not rent or sell your e-mail address.)

Endorsed by:



**THE HARTFORD**

Underwritten by:  
Hartford Life Insurance Company  
Simsbury, CT 06089

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

## 2 Check coverage amount:

\$2,000.00 (A007)

\$5,000.00 (B007)

\$10,000.00 (C007)

(Amount will be the same for each child listed below.)

## 3 Please complete information for each child:

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo day yr

Gender:  M  F Beneficiary and Relation to Child: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo day yr

Gender:  M  F Beneficiary and Relation to Child: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo day yr

Gender:  M  F Beneficiary and Relation to Child: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo day yr

Gender:  M  F Beneficiary and Relation to Child: \_\_\_\_\_

## 4 Answer the following questions:

Has anyone proposed for coverage:

YES NO

a. been treated for heart condition, diabetes, kidney or liver disease, chronic respiratory disease, neurological impairment, high blood pressure, alcohol or drug abuse or cancer during the past 5 years?  YES  NO

b. been diagnosed as having, or been treated for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)\* or any other immune deficiency disorder?  YES  NO

c. had unexplained weight loss, chronic cough, persistent diarrhea, chronic fatigue or undiagnosed symptoms during the past 5 years?  YES  NO

d. been confined in a hospital, nursing home, sanitarium or similar institution due to illness in the past 6 months?  YES  NO

**5****After reading, sign your name and date where indicated:**

I hereby certify that I am a member of AFSA and 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 Hartford Life Insurance 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, as determined by a court of competent jurisdiction. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I certify that I have received the Notice of Insurance Information Practices.

**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.

**AFSA Member Signature** **X** \_\_\_\_\_ **Date** **X** \_\_\_\_\_

**Signature of Parent or Guardian of proposed insured, if different from Member:**

**X** \_\_\_\_\_ **Date** **X** \_\_\_\_\_

\*AIDS-Related Complex (ARC) is a condition with signs and symptoms which 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 erythematosus, Graves' Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

**Don't send money now! You'll be billed later.**

Mail your completed Enrollment Form to:  
AFSA Insurance Plans • P.O. Box 14464 • Des Moines, IA 50306

**Questions?** Call Toll-Free **1-800-882-5541**

(Hearing-impaired or voice-impaired members may call the Relay Line at 1-800-855-2881.)

Or, e-mail [afsa@marshpm.com](mailto:afsa@marshpm.com)