HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
P.O. Box 2999
Hartford, CT 06104-2999
NAIC Number 88072

Hartford Life

GROUP INSURANCE APPLICATION

Application is hereby made to Hartford Life Insurance Company ("HL") on the basis of the information contained in this application, the group risk specifications, the enrollment data, and the available experience data. The application in its entirety, and any required additional information, is subject to Home Office approval before insurance can become effective.

If this application is approved by HL's Home Office, it will be attached to and made a part of the Group Policy(ies). Insurance will become effective on the requested effective date shown below, unless HL sends written notice of a different effective date.

If this application is not approved by HL's Home Office, no insurance is in effect at any time, and any deposit premium HL has received will be returned.

This application is made with the following deposit premium. The premium amount is estimated, as the amount due for the first month, and will be applied toward the first premium on the proposed Group Policy(ies): $ _____

If any insurance requires employee contributions, any underwriting requirements for enrollment must be met before insurance can become effective.

Requested effective date: _____

Coverages being applied for:

____ Life ____ AD&D ____ Short Term Disability ____ Long Term Disability
____ Other: _____

W-2 Service Option (for Short Term Disability and Long Term Disability coverage only)

____ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.
____ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established standard procedures.

Are there any companies that are subsidiaries or affiliates of the applicant, which are also to be insured? If yes, please furnish a listing, giving the name, address, effective date of coverage, and the number of employees for each such company. ____ Yes ____ No

Is the benefit plan, for which insurance is being requested, subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended? ____ Yes ____ No

If yes, identify the Plan Number: _____

Sales Representative for HL: _____

Regional Office: _____

Name of Agent/Broker: _____

For Applicant: _____
Legal Name of Entity

_____ _____
Signature Date

_____ _____
Name and Title of Authorized Signer Employer Tax ID No.