



**APPROVED BY: Air Force Sergeants Association**  
**RE: AFSA BENEFIT**

The Air Force Sergeants Association (AFSA) has approved the release of this official notification to inform you about its member benefit.

To activate your benefit, you must complete, detach and return Activator Form PA-9199 attached below for approval.

With your member benefit—the AFSA Easy Acceptance Term Life Insurance Plan – you can easily apply for up to \$150,000.00 in valuable term life coverage.

No long, complicated form to fill out.

Under this Plan, you'll also collect an additional \$1,000.00 in lump sum cash benefits if you have a heart attack, stroke or are diagnosed with cancer. This is a special additional benefit you'd be hard-pressed to find in other life plans in the general market. It's specifically designed to help give you some additional money to use any way you want — to pay extra medical expenses, household bills or other expenses — it's your choice.

As an AFSA member, you qualify for economical group rates which are not available to the general public.

Note: Your rates are this economical because when AFSA went to the bargaining table, they were armed with the full buying clout of nearly 130,000 members.

In addition, your spouse can easily enroll for this economical Life Plan, too. (The member must apply for coverage for himself or herself in order to apply for spouse coverage. Also, spouse coverage cannot exceed member coverage.)

You should give careful consideration to enrolling for coverage for you and your spouse for complete family protection. Here's why:

AFSA Headquarters often hears from members' families about the death of their loved ones. They also hear about the financial consequences when there wasn't enough life insurance – or worse – any at all.

AFSA doesn't want you or your loved ones to suffer financially if something were to happen and there wasn't enough life insurance protection. So, they negotiated for a new Plan that is extremely economical and easy to obtain.

The result: The AFSA Easy Acceptance Term Life Insurance Plan. This Plan meets all of the demanding criteria set forth by AFSA. Therefore, it carries the full endorsement of AFSA.

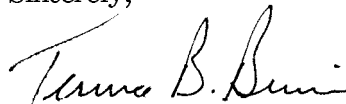
To apply for your AFSA Life Plan benefits:

1. Complete the Benefit Activator Form that is enclosed with this letter.
2. Mail today.
3. SEND NO MONEY NOW.

Once your form is received and approved, we'll issue a Certificate of Insurance you can review for 30 days. If the Plan is right for you, then pay the accompanying bill. If not, do nothing. You're under no obligation.

The opportunity you have today is one of the many benefits that comes from your membership in AFSA. Please acknowledge receipt of this notification by returning your Benefit Activator Form today.

Sincerely,



Terence B. Bernier  
Managing Director, AFSA Insurance Plans  
#2177453

P.S. Now, you can easily obtain up to \$150,000.00 in economical term life coverage and an additional \$1,000.00 additional cash benefit if diagnosed with a critical illness – thanks to the AFSA Easy Acceptance Term Life Insurance Plan. To activate your coverage, complete and return the Benefit Activator Form PA-9199 attached.

Please read the enclosed materials for more information including costs, exclusions, limitations and terms of coverage.

\*Nonsmoking rate quoted.

AGL-1725

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ISLI648L-AFSA



# AFSA EASY ACCEPTANCE TERM LIFE INSURANCE PLAN BENEFIT ACTIVATOR FORM PA-9199



### To Apply:

Send this completed form to:

**ADMINISTRATOR**  
AFSA GROUP INSURANCE PROGRAM  
P.O. BOX 14464  
Des Moines, IA 50306-9468

### QUESTIONS?

Call: 1-800-882-5541

E-Mail: AFSA@marshpm.com



**THE  
HARTFORD**

Underwritten by:  
Hartford Life and Accident Insurance Company  
Simsbury, CT 06089

Name: \_\_\_\_\_  
Last First MI  
Add 1: \_\_\_\_\_  
Add 2: \_\_\_\_\_  
City, St., Zip: \_\_\_\_\_

## 1. Please complete the following information:

### Member

Date of Birth \_\_\_\_\_  
(Mo./Day/Yr.)  
Member Number \_\_\_\_\_  
Place of Birth \_\_\_\_\_  
Sex  M  F Height \_\_\_\_\_ Weight \_\_\_\_\_  
Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

### Spouse (if applying)

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
(Mo./Day/Yr.)  
Member Number \_\_\_\_\_  
Place of Birth \_\_\_\_\_  
Sex  M  F Height \_\_\_\_\_ Weight \_\_\_\_\_

### Member's Beneficiary – Print full name and relationship to you

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
The primary insured will be the beneficiary for any spouse coverage issued.

## 2. Select your benefit amount:

Member:  \$50,000 (B/C0N1)  \$100,000 (B/C0Y1)  \$150,000 (B/CYN1)  
Spouse:  \$50,000 (B/C0N5)  \$100,000 (B/C0Y5)  \$150,000 (B/CYN5)

## 3. Please answer:

- a. At any time during the past 12 months to the present, has anyone proposed for coverage smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff?.....
- b. By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance?.....

Member		Spouse	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BE SURE TO COMPLETE ALL PAGES AND SIGN LAST PAGE

**4. Read, sign and date:**

By signing this form, I/we hereby certify that all of the information I/we have provided on this application is true and correct to the best of my/our knowledge and belief and that I/we during the past five years, have not had or been treated for a heart condition, diabetes, kidney or liver disorder, lung or respiratory disease, neurological impairment, blood or circulatory disorder (including high blood pressure), alcohol or drug abuse, cancer, enlarged lymph glands, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)\* or any other immune deficiency disorder (see below for complete definition); or have been confined in a hospital, nursing home, sanitarium or similar institution in the past six months (excluding maternity). I/we understand that coverage will become effective only after approval by the Company and receipt of the first payment of premium. By signing this application, I/we acknowledge that the application is true and accurate for each person to be insured. By signing below, I/we acknowledge that I/we have read and agree to all terms on this form.

Member's Signature **X** \_\_\_\_\_ Date **X** \_\_\_\_\_

Spouse's Signature **X** \_\_\_\_\_ Date **X** \_\_\_\_\_  
(if applying)

**CERTIFICATION and AUTHORIZATION**

I understand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the coverage, within the contestable period if such misrepresentation materially affects acceptance of the risk. I agree subject to the deferred effective date provision, that no insurance coverage shall become effective unless: a) The Hartford grants its underwriting approval; and b) at the time of payment of the first premium, I am living, and my insurability remains the same as that described in the application. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium. I certify that I have received the Notice of Insurance Information Practices.

I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; consumer reporting agency; the Medical Information Bureau, Inc., or employer; to give The Hartford 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. The Hartford 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. I authorize The Hartford 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.

<sup>1</sup>The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. The issuing company is shown on the face page of this application.

AIDS Related Complex (ARC)\* is a condition with signs and symptoms that 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.

AGL-1725  
FORM PA-9199 (1725) (HLA/HL)(SI-Life C2)  
0014407 31683 A9477 (3/07) ©Seabury & Smith, Inc. 2009

**SEND NO MONEY NOW.**

Mail this Form in the enclosed prepaid envelope to: AFSA Insurance Plans, P.O. Box 14464, Des Moines, IA 50306



ISLI648E-AFSA

**AUTOMATIC CHECK WITHDRAWAL REQUEST:** By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below. **Remember to include your first premium and a blank voided check with your application.**

Bank Name: \_\_\_\_\_

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

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer \_\_\_\_\_ Date \_\_\_\_\_

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# OUTLINE OF AFSA BENEFITS



*The following outline of the new AFSA Easy Acceptance Term Life Insurance Plan benefits is posted exclusively for AFSA members and their spouses:*

## 1. Available to AFSA members and spouses only.

The AFSA Life Plan was specifically designed for AFSA members and their spouses under age 60 who reside in the U.S., and who are not confined for medical care or treatment in an institution or at home—it is not available to the general public.

## 2. Provides up to \$150,000.00 in Term Life protection.

With this Plan, you can select the benefit amount you want up to \$150,000.00, making it ideal to either:

- Supplement your existing coverage  
OR
- Start a life insurance plan for your loved ones

## 3. Pays a \$1,000.00 cash benefit for critical illness.

If you are under age 65 and have a heart attack, stroke or are diagnosed with cancer, you will collect a \$1,000.00 lump sum cash benefit to use any way you want—to help pay extra medical expenses or household bills—the choice is yours!

## 4. Economical group rates.

Thanks to the group purchasing power of 130,000 AFSA members, your rates are very economical. See for yourself:

### Simplified Issue Plan Monthly Group Rates

Age	\$50,000 Benefit		\$100,000 Benefit		\$150,000 Benefit	
	Non-smoker	Smoker	Non-smoker	Smoker	Non-smoker	Smoker
Under age 35	\$4.00	\$7.34	\$8.00	\$14.68	\$12.00	\$22.02
35-39	5.58	10.50	11.16	21.00	16.74	31.50
40-44	8.60	16.42	17.20	32.84	25.80	49.26
45-49	13.68	26.50	27.36	53.00	41.04	79.50
50-54	24.32	47.16	48.64	94.32	72.96	141.48
55-59	41.32	81.32	82.64	162.64	123.96	243.96
60-64	57.18	111.42	114.36	222.84	171.54	334.26
65-69*	82.16	165.00	164.32	330.00	246.48	495.00
70+*	107.58	215.92	215.16	431.84	322.74	647.76

You will be billed four times a year. All billing modes except annual will include a \$2.00 billing fee. To avoid the fee, select EFT as a safe and secure payment option.

\*Critical illness benefit is available up until age 65.

You qualify for nonsmoker rates if you haven't smoked cigarettes, cigars, or used a pipe or chewing tobacco, nicotine chewing gum or snuff during the 12-months prior to the date you apply for coverage. For your convenience, you'll be billed every three months. Your individual premium is determined at each premium due date and is based on your benefit level, attained age and smoking status. Your rates are based on your attained age and increase as you enter each new age category. You can never be singled out for a rate increase or a change in benefits, and we will notify you in advance in writing of any changes. Rates and/or benefits may be changed on a class basis.

## 5. Easy to enroll.

Simply complete and return the enclosed Benefit Activator Form PA-9199.

## 6. Waives your premium if disabled.

If an illness or injury makes you Totally Disabled for at least nine consecutive months and your Total Disability starts before you're age 60, your benefits will continue at no cost to you. Your premium will be taken care of for as long as you're disabled up to age 85.

**Effective Date:** Your AFSA Life protection will start on the first day of the month after your coverage has been approved and your first premium has been paid. If on the date that you are to become covered under this Policy, you are confined for medical care or treatment at an institution or at home, coverage will not take effect until the date following your final medical discharge from such confinement.

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.

**Termination of Coverage:** You can keep your AFSA Life coverage up to age 85—no matter what your health—as long as you remain an AFSA member, pay your premiums on time and the Group Policy stays in force. Coverage for your spouse will continue for as long as he/she remains eligible due to age and marital status.

(Next page, please)

**Exclusion for Term Life Benefit:** The only thing that isn't covered is suicide during the first two years of coverage. Benefits paid for death caused by suicide while sane or insane (in Missouri, while sane) within the first two years of the effective date of insurance are limited to a refund of the premiums paid for the insured's insurance.

**Exclusions and Limitations Related to the Critical Illness Benefit:** This benefit will not be payable during the waiting period; or if the covered person dies within the 30-day period immediately following a positive diagnosis of a critical illness; or if the covered person has already received a critical illness benefit; or for a critical illness that was positively diagnosed prior to the covered person's effective date of coverage under this Plan; or for any disease, sickness or injury, except as expressly stated; or for a critical illness that is diagnosed by the insured person or any member of his/her immediate family; or for a critical illness contracted as a result of war or act of war, or service in the armed forces of any country.

- Cancer means the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes Hodgkin's disease, leukemia, lymphoma, carcinoma, sarcoma or malignant tumor. It does not include other conditions that may be considered precancerous, including, but not limited to: leukoplakia, actinic keratosis, carcinoid, hyperplasia, polycythemia, nonmalignant melanoma, moles, basal cell carcinoma, or similar diseases or lesions. Cancer does not mean carcinoma in situ.
- Heart Attack means a myocardial infarction only. Heart Attack does not include any other disease, arrhythmia or injury involving the cardiovascular system. Cardiac arrest not caused by myocardial infarction is not a Heart Attack.
- Stroke means a cerebrovascular accident that results in paralysis lasting more than 24 hours and produces measurable neurological deficit persisting for at least 30 days following the occurrence of the Stroke. Stroke does not mean a head injury, transient ischemic attack or chronic cerebrovascular insufficiency.

## 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 MIB, Inc., formerly known as 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 MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file.

Upon receipt from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Hartford or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

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.

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 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.



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## **100% SATISFACTION GUARANTEED**

There's no risk in taking a closer look at the AFSA Term Life Insurance Plan today. You don't even send money now. Simply complete and mail your Benefit Activator Form PA-9199 and we'll send you your official Certificate.

Take 30 days to look it over. When you're satisfied it's the right Plan for you, pay for it then. If it doesn't work for you, do nothing. There will be no hassles. No questions asked.

**Administered by:**

# MARSH

 MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN

P.O. BOX 14464  
Des Moines, IA 50306-9468

## **QUESTIONS?**

Call: 1-800-882-5541  
[www.afsainsurance.com](http://www.afsainsurance.com)

AR Ins. Lic. #245544  
CA License #0633005  
d/b/a in CA Seabury & Smith Insurance Program Management

Our hearing-impaired or voice-impaired members may call the Relay Line at 1-800-855-2881.

**100% Endorsed by:**



**Underwritten by:**



Hartford Life and Accident Insurance Company  
Simsbury, CT 06089

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

Form SRP-1153 A (HLA) (1725)  
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ISLI648P-AFSA

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## Important Notice to Persons on Medicare This Insurance Duplicates Some Medicare Benefits

### **This is not Medicare Supplement Insurance**

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

#### **This insurance duplicates Medicare benefits when:**

- any expenses or services covered by the policy are also covered by Medicare.
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event.

#### **Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice care
- other approved items and services.

## BEFORE YOU BUY THIS INSURANCE

1. Check the coverage in **all** health insurance policies you already have.
2. For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
3. For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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