HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

APPLICATION FOR DISABILITY INCOME BENEFITS

This application is divided into four sections, as follows:

Section I	**Administrator's Statement -** to be completed by the Administrator
Section II	**About You -** to be completed by the Insured who is applying for Disability benefits. You must complete pages 2, 3, 6 and 7. Be sure that you sign and date each place marked "signature of insured" or "signature of claimant". Proof of earnings must be provided as well as proof of actively at work status (See page 4 for explanation of acceptable documentation).
Section III	**Employer's Statement** (pages 4 & 5) - to be completed by the employer's authorized representative. If you are self-employed, complete it for yourself. Be sure to provide any necessary attachments such as job description, payroll history, tax returns.
Section IV	**Attending Physician's Statement** - to be completed by the physician who is treating you at time of disability.

Please see that all sections are fully completed and signed in order to avoid any delays in the processing of your claim. An incomplete application may delay the processing of your claim. Forward the completed application to your administrator.

If you have questions regarding this application, please contact your Plan Administrator.

Please note: A completed application will begin the investigation into eligibility for benefits. Additional information may be required.

* The definitions of "Actively at Work" and of "earnings" can be found in your certificate.

Clear Form

The Hartford
Disability Claims
P. O. Box 14295
Lexington, KY 40512-4295
Toll Free Number: 888-232-5340

APPLICATION FOR DISABILITY INCOME BENEFITS

THE HARTFORD

Section I - This section is to be completed by the Administrator of the Insurance Plan

Name of Insured Employee	Policy Number

Section II - This section is to be completed by the claimant

Information about you

Last Name: First Name: M. I. Social Security Number

Address: (Street, City, State & Zip) Gender: ☐ Male ☐ Female

Date of Birth: Marital Status: ☐ Married ☐ Single E-Mail address: ☐ Fax Number: ☐ ( )

☐ Personal Cell Telephone Number: ( ) ☐ Alternate Telephone Number: ( )

May we have your authorization to leave confidential medical and/or benefit information on your personal cell phone? ☐ Yes ☐ No

Your Signature Date

Please check above your preferred means of communication: Fax, Cell Phone Number, Home Phone Number or E-Mail. Be sure your privacy manager allows messages to be left on your home telephone number. **YOU MUST PROVIDE AT LEAST ONE TELEPHONE NUMBER.**
If you have provided a P. O. Box as your mailing address, please also include your physical address.

Dependent Information:

Last Name	First Name	M.I.	Gender: Male/Female	Birthdate(mm/dd/yyyy)
☐ Spouse: (Indicate last name if different from Employee)			☐ Male ☐ Female	
☐ Children: (under age 19)			☐ Male ☐ Female	
☐			☐ Male ☐ Female	
☐			☐ Male ☐ Female	
☐			☐ Male ☐ Female	
☐			☐ Male ☐ Female	

Medical Information

State fully the nature of your disability: *(Advise which duties of your occupation you are unable to perform.)*

What were your first symptoms?

When did you first notice them? Have you had this condition before? ☐ Yes ☐ No If so, when?

If your condition is a result of an injury, when, where, and how did the injury occur?

Physician Information

Name of Physician:	Telephone Number: ( )	Fax Number: ( )
Address of Physician: (Street, City, State & Zip)	Specialty:	
Date you first were treated by a Physician:	Are you still seeing this Physician? ☐ Yes ☐ No	Have you been referred to any other physician? ☐ Yes ☐ No

Physician Information continued

Physician' Name:	Specialty:	Telephone Number: ( )
Address of Physician: (Street, City, State & Zip)		Date of office visit
Physician's name:	Specialty:	Telephone Number: ( )
Physician's address: (Street, City, State & Zip)		Date of office visit:
Physician's name:	Specialty:	Telephone Number: ( )
Physician's address (Street, City, State & Zip)		Date of office visit:

The above information should include the name of the provider who took you off work, and the provider(s) who continue to treat you for your condition. If you have more than three providers, indicate here ☐ and provide the information on the back of the form or a separate sheet of paper.

Information about condition

Is your condition related to your occupation? ☐ Yes ☐ No If "Yes," please explain.

Before you stopped working, did your condition require you to change your job, or the way you did your job? ☐ Yes ☐ No
If "Yes," explain.

Have you filed, or do you intend to file a Workers' Compensation Claim? ☐ Yes ☐ No If "Yes," please provide name and address of Workers' Compensation Carrier and your Workers' Compensation claim number.

Workers' Compensation Carrier Name:	Claim Number:

Address: (Street, City, State, Zip Code)

Last date you worked before the disability:	Date you were first unable to work:	Do you have more than one job or employer? ☐ Yes ☐ No

Since that date have you done any work? ☐ Yes ☐ No If "Yes," please indicate dates worked, name of employer and amount earned.

If you have not returned to work, do you expect to? ☐ Yes ☐ No ☐ Part-time _____ (mm, dd, yyyy) ☐ Full-time _____ (mm, dd, yyyy)

Occupation:	License Number: (*if Licensed Professional*)	License Status:
Basic Salary or Wage: $_____ ☐ Monthly ☐ Weekly	Normal work hours & days per week	Current work status (Please check one) ☐ Full Time ☐ Part Time ☐ Retired

Name of Employer(s):	Name of Contact Person:
Title of Contact Person:	Telephone Number: ( )

Signature

The statements contained in this Application for Disability Income Benefits are true and complete to the best of my knowledge and belief. I understand that should I perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately.

Signature of the Insured: _____ Date: _____

Section III - This section is to be completed by the Employer

Employer or Business Information (If self-employed)

Employer Name or Business Name:

Contact Person:	Title of Contact Person:

Employer Address: (*Street, City, State & Zip Code)*

Telephone Number: ( )	Fax Number: ( )	Date of Hire:	Occupation:

Actual days worked per week	Actual hours worked per week:	Earnings: $ per

Current work status (check one): ☐ Lay Off ☐ Retired ☐ Paid/Unpaid sabbatical ☐ Leave of Absence ☐ Part-time ☐ Full-time

How long has insured been in this job? Is the employee's condition work related? ☐ Yes ☐ No

Proof of earnings and proof of Actively-At-Work must be provided. Please refer to your Certificate of Insurance and review the earnings definition and the Actively-at-Work provision for further detail.

If you are self-employed: Your policy may use a different time frame for pay and hours. Refer to your certificate for definitions of earnings and actively-at-work. Tax returns may be needed for more than one year. Acceptable documentation to support proof of earnings include: tax returns complete with all schedules and attachments, business tax returns complete with all schedules and attachments, W2's, or Schedule C. You may also provide monthly Profit and Loss statements for any time period not included in your tax returns. Acceptable documentation to establish Actively-at-Work includes: a work calendar, agenda, pay stubs or payroll summary for the 90 days immediately prior to your date of disability.

If you are not self.employed: Employer must sign and complete pages 4 and 5. Attach payroll history including hours worked for the 90 days prior to the date of disability. Your policy may use a different time frame for pay hours. Refer to your certificate for definitions of earnings and actively at work.

Claim Information

Were there any changes to the insured's job responsibilities due to the disabling condition before the insured became totally disabled? (Please check one.) ☐ Yes ☐ No If "Yes, what were the changes and when were they made?

What was the insured's permanent job on the last day worked?

How long has the insured been at this job?	Last day actually worked:

Is the insured's condition work related? ☐ Yes ☐ No

Date of return to work: ☐ Expected ☐ Actual

Name and address of Workers' Compensation Carrier: (if condition is work related)

Information About the Physical Aspects of the Insured's Job

Please check the items below that relate to the insured's job and complete the information requested. Use these definitions for the frequency of occurrence: **Not Applicable (N/A): the person does not perform this activity; Occasionally: the person performs this activity 33% of the time; Frequently: the person performs this activity 34 - 66% of the time; Continuously: the person performs this activity 67 - 100 % of the time.**

Activity	N/A	Occasionally	Frequently	Continuously
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Reaching / working overhead	☐	☐	☐	☐
Keyboard Use	☐	☐	☐	☐
Repetitive Hand Motion	☐	☐	☐	☐
Climbing	☐	☐	☐	☐

Activity	Description	Frequency	Weight
Pushing			lbs.
Pulling			lbs.
Lifting			lbs.
Carrying			lbs.
Driving			

Can the job be performed by alternating sitting and standing? ☐ Yes ☐ No

What are the major tasks requiring the use of one or both hands? (Indicate the percentage of the insured's workday that is spent on each of these tasks?)

_____ %

_____ %

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No If "Yes," explain:

Is it possible to offer the insured assistance in doing the job: (e.g., through use of technology or personal assistance?) ☐ Yes ☐ No

Signature (If self-employed, insured must sign). If job description is available, please attach.

Employer Signature:	Date:	( ) Telephone Number:	( ) FAX Number:

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: 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. 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who 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 is guilty of a felony of the third degree

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of New York: 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 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: 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 information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: 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 information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Clear Form

THE HARTFORD

To: Any health care provider, employer, benefit plan, insurer, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to The Hartford[1] a complete copy of any and all of the following personal or privileged information, records or documents relative to:

Insured's Name (*Please print*) | Date of Birth | Last 5 digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, and payment records; academic transcripts; and information concerning Social Security benefits, including, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits under my benefit plan. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

I ALSO UNDERSTAND that once My Information has been disclosed to The Hartford, as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. I authorize The Hartford to use or disclose My Information (i) to my employer for functions related to accommodating my disability; (ii) to the administrator or other service providers of my benefit plan for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related to my claim; vi) to my employer's workers' compensation insurance carrier or administrator; (vii) as may be lawfully required; or (viii) as may be necessary to prevent or detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian | Date | Relationship to Insured (*if signed by Guardian*)

[1] The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and its administrative services company Hartford-Comprehensive Employee Benefit Service Company, and any of their parents, affiliates, subsidiaries and/or third-party contractors. Also as used herein, The Hartford provides insurance or claim administration services benefit plan(s).

THE HARTFORD

To be completed by the Insured

Name of Patient:	Social Security Number:	Date of Birth:

Address of patient : *(Street, City, State or Province, Zip Code or Postal Code)*

Policyholder name: *(and division, if applicable)*	Policy Number

I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.

_____ Date: _____

To be completed by the Attending Physician

(The patient is responsible for the completion of this form without expense to the Company.)

DIAGNOSIS

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy Height _____ Weight _____

If pregnancy, what is the expected date of delivery? Month _____ Day _____ Year _____

Is condition due to illness or an injury that is work related? ☐ Yes ☐ No

Primary diagnosis: _____ ICD-9 Code: _____

Secondary diagnosis(es): _____ ICD-9 Code(s): _____

Subjective symptoms: _____

Test Results (list all results, or enclose test):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Physical examination findings: _____

_____

If pregnancy, indicate LMP date: Month _____ Day _____ Year _____

TREATMENTS

Date you first treated this patient: _____ Date you first treated this patient for this condition: _____

Date of onset of this condition: _____ Date of most recent treatment: _____

How often has patient been seen/treated? _____ Date of next office visit: _____

Has patient been referred to any other physician? ☐ Yes ☐ No If "Yes," Date(s) _____

Name and address: _____

_____ Specialty: _____

Nature of treatment for this condition: _____

Has surgery been performed? ☐ Yes ☐ No

If "Yes," Date: _____ Procedure: _____ CPT Code: _____

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," Date(s) admitted: _____ Date (s) discharged: _____

_____ _____

Name and address of hospital(s): _____

_____

Progress *(Please check one.):* ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

IMPAIRMENT

If the patient's ability to perform any of the following activities is limited by his/her disorder, please describe the extent of the limitation and its expected duration.

Standing: _____

Walking: _____

Sitting: _____

Lifting / carrying: _____

Reaching/working overhead: _____

Pushing: _____

Pulling: _____

Driving: _____

Keyboard use/repetitive hand motion: _____

If any other activities are limited, please specify the activities and the limitations: _____

If the patient's vision is impaired, please describe the extent of the impairment: _____

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

What is the psychiatric impairment (*if applicable)?*

- ☐ Inadequate information to make assessment.
- ☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
- ☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.
- ☐ Major impairment in several areas -- work, family relations. Avoidant behavior, neglects familiy, is unable to work.
- ☐ Inability to function in almost all areas.

Date patient became unable to work due to this impairment? Month _____ **Day** _____ **Year** _____

If physical or psychiatric limitations exist, how long do you feel limitations will last? _____

Attending Physician's Name: _____ Telephone Number ( ) _____

License Number: _____ Fax Number: ( ) _____

SS# or E.I.N.#: _____ Degree: _____ Specialty: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Signature: _____ Date signed: _____