



**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 **Insured's Statement** - to be completed by the Insured who is applying for Disability benefits. The Insured's Statement and the attached Authorization to Release Information must both be completed, signed and dated (pages 3&7). Proof of earnings must also be provided, as well as proof of actively at work status.* (See Sections I and II.)

- Section III **Employer's Statement** - 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.

- Section IV **Attending Physician's Statement** - to be completed by the physician who is treating the Insured 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.

APPLICATION FOR DISABILITY INCOME BENEFITS



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

Name of Insured Employee	Policy Number
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Section II - This section is to be completed by the claimant

Personal Information

Last Name:	First Name:	M.I.	Social Security Number:
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Address: (Street)	(City)	(State/Province)	(Zip Code)
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Date of Birth: (mm, dd, yyyy)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single
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<input type="checkbox"/> Telephone Number: (Home) ()	<input type="checkbox"/> Fax Number: ()	<input type="checkbox"/> Cell Number: ()	E-Mail address:
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Please check above your preferred means of communication: Fax, 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:	M.I.	Gender: Male/Female	Birthdate: (mm/dd/yyyy)				
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Last Name</td> <td style="width: 30%;">First Name</td> <td style="width: 10%;">M.I.</td> <td style="width: 30%;"></td> </tr> </table> <input type="checkbox"/> Spouse: (Indicate last name if different from Employee)	Last Name	First Name	M.I.			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Last Name	First Name	M.I.					
<input type="checkbox"/> Children:		<input type="checkbox"/> Male <input type="checkbox"/> Female					
		<input type="checkbox"/> Male <input type="checkbox"/> Female					
		<input type="checkbox"/> Male <input type="checkbox"/> Female					
		<input type="checkbox"/> Male <input type="checkbox"/> Female					

Medical Information

State fully the nature of your disability: <i>(Advise which duties of your occupation you are unable to perform.)</i>
What were your first symptoms?
When did you first notice them? _____ Have you had this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been referred to any other physician? <input type="checkbox"/> Yes <input type="checkbox"/> No

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:	
Address: <i>(Street, City, State & Zip Code)</i>				
Telephone Number: ()			Fax Number: ()	
Date of Hire:	Occupation:	Actual days worked per week:	Actual hours worked per week:	Earnings:
Current work status (check one): <input type="checkbox"/> Lay Off <input type="checkbox"/> Retired <input type="checkbox"/> Paid/Unpaid sabbatical <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time				
Proof of earning 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. 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, pay stubs, payroll summary, 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 one month immediately prior to your date of disability.				
*Please note: if you are self employed, you must also provide proof of earnings and information to establish your Actively-at-Work status. Please review your Policy for further explanation.				

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.) <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of return to work: _____ <input type="checkbox"/> Expected <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching / working overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keyboard Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)

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

APPLICATION FOR DISABILITY INCOME BENEFITS



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

For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Oregon, Virginia and Puerto Rico: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

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 New Jersey, Arkansas, and New Mexico: 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 an insurance policy is subject to criminal and civil penalties.

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 thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: "ANY PERSON WHO KNOWINGLY PRESENTS A 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 Louisiana: 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 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 Puerto Rico: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

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

Signature _____ Date _____

**HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**



Name of Claimant _____ Date of Birth _____ Social Security Number _____

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies who has provided payment, treatment or services to me or on my behalf within the last 10 years,

Any past or present employer;

Any group insurance policyholder, insurance contract holder, insurance company or reinsurance company, benefit plan administrator, claims administrator that has provided payment, treatment or services to me or on my behalf within the last 10 years and Insurance Services Office, Inc.,

I have filed a claim for insurance coverage under a group life, accidental death and dismemberment and/or disability income policy issued by Hartford Fire Insurance Company, Hartford Life Insurance Company and/or Hartford Life and Accident Insurance Company. This Authorization is intended to comply with the requirements of §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") effective April 14, 2003. However, by signing this Authorization, I understand that Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company and their affiliates, employees, representatives and agents (collectively "Hartford") are not subject to the requirements of HIPAA. Hartford will use information received in accordance with this Authorization for the purpose of evaluating and administering claims for group life, accidental death and dismemberment and/or disability income benefits.

By signing this Authorization, I authorize you to release and disclose to Hartford, a complete copy of any and all health information, including but not limited to x-rays, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, toxicology/drug reports, autopsy reports and treatment notes (collectively, "Health Information"). For purposes of this Authorization, Health Information specifically includes confidential information regarding HIV/AIDS; sexually transmitted diseases and communicable diseases, alcohol or drug use, and treatment of mental illness, but excludes psychotherapy notes as defined by HIPAA.

By signing this Authorization, I acknowledge and agree that any agreements I have made to restrict disclosure of my Health Information do apply to this Authorization and I authorize any person or entity identified above to release and disclose my complete medical file with out restriction.

By signing this Authorization, I acknowledge that I understand the following:

- That any Health Information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the knowledge of any person or entity authorized to disclose the Health Information. Note that Hartford will only use Health Information obtained under this Authorization for the purpose of evaluating and administering claims for group life, accidental death and dismemberment and/or disability income benefits, including obtaining reinsurance and conducting legal and business activities that relate to such claims. Hartford will only disclose Health Information obtained under this Authorization in accordance with its Corporate Privacy Policy.
- That my claim for benefits may be delayed and/or denied if Hartford is unable to obtain Health Information necessary to properly assess my claim because I do not properly sign, date, and deliver this authorization or any person subject to HIPAA that receives it does not comply with it.
- That, if necessary, Hartford will send this authorization to persons or entities authorized to release Health Information about me. I have a right, at any time, to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will not be effective to the extent that action has been taken in reliance upon this Authorization or Hartford otherwise has the right to contest the policy or claim under the policy.
- That this Authorization will expire two (2) years from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original and I am entitled to a signed copy of this

Signature of Claimant or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relation to Insured (Required if signed by personal representative)

APPLICATION FOR DISABILITY INCOME BENEFITS
(Altering or failure to sign this form may delay your claim)



Authorization to Obtain and Release Information

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies;

Any employer, group policyholder, contract holder or insurer, benefit plan administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or

Any Federal, State or Local Government Agency, including Social Security and Veterans Administration.

I authorize you to release and send to: (i) Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life & Accident Insurance Company, and any affiliates of these three companies, known collectively as The Hartford, or (ii) The Hartford's representatives, a complete copy of any and all of the following information, records or documents relative to:

Insured's Name (Please Print)

Date of Birth

Social Security Number

1. Any and all medical information, including x-ray films, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits.
2. Work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims: credit information, including, but not limited to, credit reports and credit applications; other financial information, e.g., bank records: business transactions of any kind or description, including billing, invoices or payment records of any kind: and academic transcripts.
3. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record, I understand that the information obtained by use of the Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by The Hartford to any person or organization EXCEPT to reinsuring companies or their representatives, The Index System, physicians who have treated me, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required, or as I may further authorize, or as may be necessary to prevent or to detect the perpetration of a fraud.

I know that I may request to receive a copy of this Authorization. This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

Signature of Insured or Guardian

Relationship to Insured (If signed by Guardian)

Date



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 _____)

Employer's name: (and division, if applicable) _____

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

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 family, 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: _____