



HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

**APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS**

- Section I**      **Employer's Statement** - to be completed by the employer's authorized representative. Be sure to provide any necessary attachments (see Section K).
- Section Ic.**    **Information for Group Life Premium Waiver Benefits** - to be completed by the employer's authorized representative if the employer also has a Group Life Insurance policy with The Hartford that includes a Premium Waiver benefit. Be sure to provide any necessary attachments (see Section K)
- Section II**     **Employee's Statement** - to be completed by the employee who is applying for Long Term Disability benefits. Please attach a copy of the employee's driver's license.
- Section III**    **Authorization to Obtain Information** - to be signed by the employee.
- Section IV**    **Attending Physician's Statement** - to be completed by the physician who is treating the employee.

**PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO YOUR HARTFORD BENEFIT MANAGEMENT SERVICE CENTER.**

HARTFORD LIFE INSURANCE COMPANY  
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APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS



Section II - Employee's Statement

To be completed by the Employee ( BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM )

A. Information about you

Last name	First	Middle Initial	Social Security Number
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Address (Street)	City	State/Province	Zip
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Telephone Number \_\_\_\_\_

Date of Birth (Month, Day, Year)	Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed
			<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced

Your employer (include division, if applicable)	Occupation
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When your disability began, did you have more than one employer (includes self-employment)?  Yes  No If "Yes," please provide the name, address and phone number of that employer. Indicate the dates when you worked (or were self-employed).

Please indicate the extent of your formal education (Circle one)

High School: 1 2 3 4 5 6 7 8 9 10 11 12  
College: 1 2 3 4 Masters \_\_\_\_\_ Ph.D. \_\_\_\_\_

Trade School: \_\_\_\_\_ Current Occupational Licenses: \_\_\_\_\_

Briefly describe your past work experience for the last 20 years (Begin with your most recent job.)

Job Title	Duties	Years Worked
(a)		
(b)		
(c)		

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work?  Yes  No

Have you contacted your State Department of Vocational Rehabilitation?  Yes  No If "Yes," please include the name, address and telephone number of your counselor.

B. Information About your Family (required to determine your eligibility for Social Security Benefits)

Spouse's Name (Last, first)

Spouse's Social Security Number	Date of Birth (Month, Day, Year)	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you have any children under Age 19?  Yes  No If "Yes," please provide the information requested below for each child.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Do you have any children with disabilities (regardless of age)?  Yes  No If "Yes," please provide the information requested below for each child.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

C. Information About the Condition Causing Your Disability

1a. For illness, answer the following questions:

What were your first symptoms?

When did you first notice them?	Have you had this illness before? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?
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**C. Information About the Condition Causing Your Disability (cont'd...)**

1b. Next to any Activity of Daily Living (ADL), please place the number shown next to the statement that most accurately reflects your ability/inability to perform each: 1 = I can perform this activity independently; 2 = I can perform this activity with the use of equipment or adaptive devices; 3 = I cannot perform this activity.

- ( ) Bathe (tub, shower, or sponge)      ( ) Transfer from Bed to Chair
- ( ) Dress      ( ) Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene.
- ( ) Toilet      ( ) Feed yourself with food that has been prepared and made available to you.

If you indicated (3) for any of the above activities, please describe the impairment and restrictions to your functionality that preclude you from performing this activity.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you suffered a severe Cognitive Impairment that renders you unable to perform common tasks, such as using the phone, money management, or medication management?  Yes  No If "Yes," describe:

**2. For an injury, answer the following questions:**

When, where and how did the injury occur?

**3. For Illness, Injury or Pregnancy, answer the following questions:**

Date you were first treated by a physician? (Month Day Year)	Name of Physician _____ Address of Physician _____
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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:

What aspect of your condition made you unable to work?

Is your condition related to your occupation?  Yes  No If "Yes," explain:

Have you filed, or do you intend to file a Workers' Compensation claim?  Yes  No

**D. Information About the Disability**

Last day you worked before the disability (Month Day Year)	Did you work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain	Date you were first unable to work (Month Day Year)
Since that date, have you done any work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please indicate dates worked, name of employer, and amount earned.		If you have not returned to work, do you expect to? <input type="checkbox"/> Yes Part time _____ Full time _____ <input type="checkbox"/> No (date) (date)

**E. Information About Physicians and Hospitals**

First medical attention for the current disability was given by (complete below)

Doctor's Name	Telephone FAX	Specialty
Address (Street, City, State, Zip)		Dates seen to

List all Physicians and Hospitals you have seen for this condition (attach separate sheet, if needed)

Doctor's Name	Telephone FAX:	Specialty
Address (Street, City, State, Zip)		Dates seen to

Hospital	Dates of Confinement to
Address (Street, City, State, Zip)	

Have you consulted any other physicians or been hospitalized in the past three years?  Yes  No  
If "Yes," complete the following concerning your past treatment (attach separate sheet, if needed)

Doctor's Name	Telephone FAX:	Specialty
Address (Street, City, State, Zip)		Dates seen to

Hospital	Dates of Confinement to
Address (Street, City, State, Zip)	

**APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS**

**F. Other Income**

Check the other income benefits you have received/are receiving, or are eligible to receive during your disability (complete the information requested).

<u>Source of Income</u>	<u>Amount(week /month</u>	<u>Date Claim was filed</u>	<u>Date Payments began</u>	<u>Date Payments ended</u>
Social Security/Retirement	\$ _____ / _____	_____	_____	_____
Social Security/Disability	\$ _____ / _____	_____	_____	_____
Sick Pay or Salary Continuation	\$ _____ / _____	_____	_____	_____
Income from Work	\$ _____ / _____	_____	_____	_____
Workers' Compensation	\$ _____ / _____	_____	_____	_____
State Disability	\$ _____ / _____	_____	_____	_____
Pension/Retirement	\$ _____ / _____	_____	_____	_____
Pension/Disability	\$ _____ / _____	_____	_____	_____
Short Term Disability	\$ _____ / _____	_____	_____	_____
Unemployment	\$ _____ / _____	_____	_____	_____
No-Fault Insurance	\$ _____ / _____	_____	_____	_____
Other (include Individual or Group benefits)	\$ _____ / _____	_____	_____	_____

**G. Information about Tax Withholding**

Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is \$88.00 per month): \$ \_\_\_\_\_ .00. **IMPORTANT:** If you pay the entire cost of the LTD premium, but on a Post-tax basis per Section I, Part D of the Employer's Statement, you will not be able to request any federal income tax withholding from your check.

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

H. Signature

With the exception of any source(s) of income reported above in Section F of this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my Hartford Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately.

If I receive disability benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

**For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, 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.** (In Oregon, a fraudulent insurance act may be 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.

The statements contained in this application for Long Term Disability Income Benefits are true and complete to the best of my knowledge and belief.

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of the Employee Date

PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR ANOTHER DOCUMENT THAT VERIFIES YOUR DATE OF BIRTH.

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Authorization to Obtain and Release Information

Section III

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, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or

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

I authorize you to release and send to: (i) Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and any affiliate of one or more 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., Pension Benefits, 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

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Attending Physician's Statement of Disability

Section IV

To be completed by the Employee

Name of patient \_\_\_\_\_ Social Security Number \_\_\_\_\_ D.O.B. \_\_\_\_\_

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. Signed (Patient) \_\_\_\_\_ Date: \_\_\_\_\_

To be completed by the Attending Physician (The patient is responsible for the completion of this form without expense to the Company.)

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

DIAGNOSIS

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

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Attending Physician's Statement of Disability (page two)

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 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 # \_\_\_\_\_  
(Please print or type.)

License No. \_\_\_\_\_ Fax # \_\_\_\_\_

SS# or E.I.N.#: \_\_\_\_\_ Degree: \_\_\_\_\_ Specialty \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_