HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

This application package is divided into four sections, as follows:

Section I **Employer's Statement** - to be completed by the **employer's** authorized representative.

Section II **Employee's Statement -** to be completed by the **employee** who is applying for Short Term Disability Benefits

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.**

Fax completed application to:

The Hartford
P.O.Box 14301
Lexington, KY 40512-4301
Fax Number: (866) 411-5613

Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly.

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

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Lexington, KY 40512-4301
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HARTFORD LIFE INSURANCE COMPANY
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APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

THE HARTFORD

Section I - Employer's Section

To Be Completed by the Employer

Clear Form

This claim is for (Employee's Name)	Social Security Number	Date of Birth
Employee's Address (Street, City, State, Zip)		Telephone Number ( )

A. Information About the Employer

Company's Name

Address (Street, City, State, Zip)

Name and Address of Division Where Employee Works (if different from above)

Group Policy Number	Class	Location

B. Information About the Employee

Date employee was hired	Date employee became insured under this plan

What was the employee's regularly scheduled work week?

_____ Hours per Week _____ Scheduled workdays M - F Other: _____

IS EMPLOYEE ENROLLED IN THE HARTFORD'S LONG TERM DISABILITY PLAN ? ☐ Yes ☐ No IF "YES," EFFECTIVE DATE _____

Was the employee's STD insurance issued on the basis of a Personal Health Statement? ☐ Yes ☐ No If "Yes, attach copy.

Was the employee insured under your prior STD policy? ☐ Yes ☐ No

If "Yes," please provide the inclusive date of coverage. From _____ Through _____

Was the employee on Qualified Family Leave when disability began? ☐ Yes ☐ No

Did STD & LTD insurance continue while on Family Leave? ☐ Yes ☐ No

Date Leave of Absence started under Family Leave Act: _____

C. Information Needed for Withholding and Reporting Taxes

What percent of this employee's STD benefit is taxable? _____ %.

What percentage, if any, do you contribute towards the cost of the STD premium? _____ %

Does the employee contribute towards the cost of the STD premium? ☐ Yes ☐ No. If "Yes," at what percent? _____ %.

Is it on a ☐ Pre or ☐ Post-tax basis?

What percent of this employee's LTD benefits is taxable? _____ %

Does the employee contribute towards the cost of the LTD premium? ☐ Yes ☐ No. If "Yes," at what percent? _____ %

Is it on a ☐ Pre or ☐ Post-tax basis?

D. Information About the Claim

What was the employee's permanent job on his or her last day at work? (Please attach a copy of the employee's job description.)

Last day employee actually worked:	On that day, did the employee work a full day? ☐ Yes ☐ No If "No," how many hours were worked? _____

Why did employee stop working?

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

Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No If "Yes," send initial report of illness or injury or award notice.	Date employee is expected to return to work? _____ Full time? ☐ Yes ☐ No

E. Information About Salary

Employee's weekly/hourly rate of pay: $_____

Will/Is Employee receive(ing) Workers' Compensation Payments? ☐ Yes ☐ No

Weekly Amount: $_____ Date Payments Start: _____ Date Payments Will End: _____

Is employee receiving Salary Continuance or Sick Leave? ☐ Yes ☐ No

Weekly Amount: $_____ Date Payments Start: _____ Date Payments Will End: _____

F. Information About the Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

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

Activity	Description	Frequency	Weight
☐ Pushing	_____	_____	_____ lbs.
☐ Pulling	_____	_____	_____ lbs.
☐ Lifting	_____	_____	_____ lbs.
☐ Carrying	_____	_____	_____ lbs.

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 employee's workday that is spent on each of these tasks. _____ _____ %

_____ _____ %

_____ _____ %

G. Information About the Job as it Relates to the Disability

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

_____

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

H. Signature

_____ _____

Name (Please print or type) *Title*

_____ _____

Signature *Date*

( ) _____ ( ) _____

Area Code Telephone Number Area Code Fax Number

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The Hartford P.O. Box 14301
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Section II - Employee's Section

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: | Gender: ☐ Male ☐ Female | Date of Birth: | Social Security Number:

Address: (Street, City, State & Zip) | Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

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

Signature Date E-Mail Address:

E-Mail is used to provide The Hartford At Work registration instructions and important status updates.

B. For an Injury, answer the following questions

When (i.e., date/time), where and how did the injury occur?

C. For Illness, Injury or Pregnancy, answer the following questions

Name of Physician: | Date you were first treated by a physician: (MM/DD/YYY)

Address of Physician: (Street, City, State & Zip) | Telephone Number: ( )

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?

Are you receiving or eligible for: ☐ Workers' Compensation ☐ State Disability ☐ No Fault Disability ☐ Other
If "Yes," show policy number: and name and address of insurer:

Weekly Amount: $ Date Payments Start: Date Payments Will End:

Is your condition related to work activities or your workplace? ☐ Yes ☐ No If "Yes," explain:

Have you filed, or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No If "No," explain:

D. Information About the Disability

Last day you worked before the disability: | Did you work a full day? ☐ Yes ☐ No If "No," explain:

Your Employer: (include division, if applicable)

If you have not returned to work, do you expect to? ☐ Yes ☐ No Date you were first unable to work:

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

Name of employer and amount earned.

E. 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 $ 20.00 per week). $ _____.__00.__ **IMPORTANT:** If you pay the entire cost of the STD premium, but on Post-tax basis per Section C of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed state Tax Withholding Certificate from you. Please cont act your employer or st ate Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed federal Form W -4, Employee's Withholding Allowance Certificate, from you. You may go to www .irs.gov to obtain the proper withholding form.

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

With the exception of any source(s) of income reported above in 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 disability benefits from this plan. 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 income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford 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, 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 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 _____

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

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

Section III **AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

To: Any health care provider, employer, benefit plan, insurer, service provider, 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 4 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; work information and history, including job duties, earnings, 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 and bank records; business transactions billing, invoice, 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 and/or leave request. 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 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 a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to complaints by me or my representative relating to benefits or leave; d) responding to any litigation or agency document production request or lawful subpoena; e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers of my employer's benefit plan, other benefits, and/or leave programs of my employer for plan, benefit, or program related functions or data aggregation and analysis; (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, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; or (ix) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO 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(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud or protect the personal safety of others. 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.

Section IV Attending Physician's Statement

HISTORY **Fax completed application to: The Hartford, P.O. Box 14301, Lexington, KY 40512-4301 Fax Number: (866) 411-5613**

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

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy ☐ Mental/Nervous Condition

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

If pregnancy, what is the expected date of delivery? Month_____ Day_____ Year_____ LMP Date_____

DIAGNOSIS

Diagnosis: (including any complications)	CD9 Codes:

Subjective Symptoms:

Physical Findings: (list all test results, or enclose test)

Test:_____ Date:_____ Results:_____

Test:_____ Date:_____ Results:_____

Blood Pressure: (Systolic)_____ (Diastolic)_____ (Date)_____

Remarks:

TREATMENT

Date of onset of this condition?	List all dates of treatment for this condition since patient ceased work:	Date of next office visit:

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

Name:	Address:	Specialty:

Nature of treatment for this condition: (including surgery/medications)

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

Name of Hospital(s):_____ Date(s) discharged: _____ _____

Address:_____

Was surgery performed? ☐ Yes ☐ No If "Yes," Date:_____ Procedure:_____ CPT Code:_____

Progress: (please check one) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

IMPAIRMENT

What are the patient's current physical limitations and restrictions?

☐ No limitation of functional capacity; capable of heavy work, no restrictions.
(Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)

☐ Medium manual activity
Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)

☐ Slight limitation of functional capacity; capable of light work
Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.)

☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity
(Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)

☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity

What is the psychiatric impairment (if applicable)?

☐ Inadequate information to make assessment.

☐ Essentially good functioning in all areas. Occupationally and socially effective.

☐ 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 ceased work due to this impairment: _____

If physical or psychiatric limitations exist, indicate the date limitations lasted, or will last through: _____

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

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

Social Security Number or E.I.N. Number:	Degree:	Specialty:

Signature:	Date Signed: