Clear Form

HARTFORD LIFE GROUP 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.**

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

THE HARTFORD

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

HARTFORD LIFE GROUP INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Section I

Employer's Statement

To Be Completed by the Employer

This claim is for *(Employee's Name)*	Social Security Number	Date of Birth

Employee's Address *(Street, City, State, Zip)*

A. Information About the Employer

Company's Name	Group Policy Number

Address *(Street, City, State, Zip)*

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

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

Based on the employer/employee premium contributions made over the last 3 years, what percentage of the STD _____ %

LTD _____ % benefit is considered taxable? *(See IRS Publication 15-A for information on determining the taxable percentage.)*

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/did return to work? _____

Full time ? ☐ Yes ☐ No

E. Information About Salary

Employee's weekly/hourly rate of pay $ _____

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

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

Will/Is Employee receive(ing) Workers' Compensation Payments? ☐ 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	☐	☐	☐	☐
☐ Reaching/Working Overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐

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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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

Address *(Street)* | City | State/Province | Zip

Telephone Number ( ) Area Code | Date of Birth *(Month, Day, Year)* | ☐ Male ☐ Female | ☐ Single ☐ Married | ☐ Widowed ☐ Divorced

Your Employer *(include division, if applicable)*

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

Date you were first treated by a physician

(Month) (Day) (Year)

Name of Physician

Address of Physician

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 your occupation? ☐ 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

(Month (Day) (Year)

Did you work a full day? ☐ Y es ☐ No
If "No," explain.

Date you were first unable to work

(Month (Day) (Year)

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 Part time *(date)* Full time *(date)*
☐ No

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.

F. Signature

With the exception of any source(s) of income reported above in Section D of this form, I certify by my signature that I have not received 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, Oregon, and Virginia: 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.

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

X _____ X _____

SIGNATURE OF THE EMPLOYEE *DATE*

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, 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, Hartford Life Group Insurance Company, and any affiliate of one or more of these four 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

Attending Physician's Statement

HISTORY

Patient's Name _____ SSN _____ D.O.B. _____ Height _____ Weight _____

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

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

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

DIAGNOSIS

Diagnosis *(including any complications)* _____

ICD9 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 Date(s) _____

If "Yes," name and address _____ Specialty _____

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

_____

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

Name and Address of Hospital(s) _____

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: _____ *(Month)* _____ *(Day)* _____ *(Year)*

If physical or psychiatric limitations exist, indicate the date limitations have lasted, or will last through: _____ *(Month)* _____ *(Day)* _____ *(Year)*

Attending Physician's Name _____ Telephone #: ( ) _____ *Area Code* Fax # ( ) _____ *Area Code*

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

Street Address _____ City _____ State _____ Zip Code _____

Signature _____ Date Signed _____