

HARTFORD LIFE INSURANCE COMPANY HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

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

Section	I 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.



APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS HARTFORD LIFE INSURANCE COMPANY HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Section II Employee's Statement

A. Information about you	First		Middle Initial	Social Security	Number
	T Hot				
Address (Street)		City	State/Province	Zij	0
elephone Number					
Date of Birth (Month, Day, Year)	Height	Weight	Male	Single	Widowed
Your employer (include division, if applical	ble)			Occupation	
When your disability began, did you ha provide the name, address and phone					
Please indicate the extent of your form	al education (Circle c	one)			
High School: 1 2 3 4 5 College: 1 2 3 4	6 7 8 9 1	10 11 12	Masters	Ph.D	
Trade School:					
Briefly describe your past work experie	ence for the last 20 y	ears (Begin with			Veere Merker
Job Title			Duties		Years Worked
(a)					
<u>(b)</u>					
(c)					
Now, or at some time in the future, wo	<u> </u>			kind of work?	es No
Have you contacted your State Departi If "Yes," please include the name, add	ment of Vocational R dress and telephone	ehabilitation?	_YesNo counselor.		
B. Information About your Family (red	nuired to determine you	r eliaibility for Soci	al Security Benefits)		
Spouse's Name <i>(Last, first)</i>		engloundy for coor			
Provosla Pasial Pasurity Number	Data of Pirth (Aanth Davi Vaari			Datirado
Spouse's Social Security Number	Date of Birth (Month, Day, Year)	Is your spouse emplo		Retired? /es
Do you have any children under Age 1 If "Yes," name and date of birth of eac					
Do you have any children with disabiliti If "Yes," name and date of birth of eac		? Yes	No		
C. Information About the Condition C		lity			
1a. For illness, answer the following What were your first symptoms?	questions:				
Mat were your mist symptoms?					
When did you first notice them?		ŀ	lave you had this illness	before? Yes	No If so, when?

C. Information About the Condition Causing Your Disability (cont'd...)

	outoing rou bloubing (cont an)					
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) () Dress () Toilet 	 () Transfer from Bed to Chair () Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene. () Feed yourself with food that has been prepared and made available to you. 					
If you indicated (3) for any of the above from performing the activity.	ve activities, please describe the impairment and restrictions to your functionality that preclude you					

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, answ	ver the following questions	s:	
Date you were first treated by a physician?	Name of Physician		
	Address of Physician		
(Month Day Year)			
Before you stopped working, did your cond	ition require you to change y	your job, or the way you did your jol	b? Yes No If "Yes," explain:
What aspect of your condition made you un	nable to work?		
Is your condition related to your occupation	? Yes No If "Yes," e	explain:	
Have you filed, or do you intend to file a Wo	orkers' Compensation claim	? Yes No	
D. Information About the Disability			
Last day you worked before the disability)id you work a full day? []וּ	Yes No If "No," explain:	Date you were first unable to work
(Month Day Year)			(Month Day Year)
Since that date, have you done any work?	Yes No_If "Yes," plea	se If you have not returned	to work, do you expect to?
indicate dates worked, name of employer,	and amount earned.	Yes Part time <i>(date)</i>	Full time (date)
		No	
E. Information About Physicians and Hos	spitals		
First medical attention for the current dis	sability was given by (com	plete below)	
Doctor's Name		Telephone	Specialty
		FAX	
Address (Street, Clty, State, Zip)			Dates seen
			to
List all Physicians and Hospitals you ha	ve seen for this condition	(attach separate sheet, if needed)	
Doctor's Name		Telephone FAX	Specialty
Address (Street, City, State, Zip)		I	Dates seen
			to
Hospital			
Address (Street City State Zin)			Dates of Confinement

	Batter of Commontent		
			to
Have you consulted any other physicians or been ho If "Yes," complete the following concerning your pas	· · · · ·		
	t treatment (allach separate sheet, il het	eueu)	
Doctor's Name	Telephone FAX		Specialty
Address (Street, City, State, Zip)			Dates Seen
			to
Hospital			

Hospital

Address (Street, City, State, Zip)

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).

Source of Income	Amount(week /month)	Date Claim was filed	Date Payments began	Date Payments ended
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 \$87.00 per month)*: \$_____.00.

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, 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, New Mexico, and Louisiana: Any person who knowingly files a statement of claim containing anyfalse 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 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 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 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 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.

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

Х		X	
Λ	SIGNATURE OF THE EMPLOYEE		DATE

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



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, 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 (<i>Please print.</i>)	
(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, and 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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THE SEA	
HARTFORD	

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

Section IV

ATTENDING PHYSICIAN'S STATEMENT OF DISABILI	ГҮ				
To be completed by the Employee					
Name of patient	Social S	ecurity Number		– D.O.B –––	
Address of patient		City	State or Province	•	Zlp Code or Postal Code
Employer's name (and division, if applicable)		•			
I hereby authorize release of information on this for named physician for the purpose of claim processing				D.	ate:
To be completed by the Attending Physician (The p	atient is resp	onsible for the co	ompletion of this	form without e	expense to the Company.)
Patient's condition is the result of:	Injury	Pregnancy	Heig	ght	Weight
If pregnancy, what is the expected date of delivery?	Month	Day	Yea	ır	
Is condition due to illness or an injury that is work rel	ated? 🗌 Yes	s 🗌 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	S:		
Test:	Date:	Results	S:		
Physical examination findings:					
If pregnancy, indicate LMP date: Month	Day	Yea	ır		
TREATMENTS					
Date you first treated this patient:	Date you	first treated this	patient for this co	ndition:	
Date of onset of this condition:	Date of most re	ecent 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 "Ye	es," Date:	Proce	edure:		CPT Code:
Was patient hospitalized for this condition?					
				<u> </u>	
Name and address of hospital(s):					
				.	
Progress (Please check one.): Recovered		ed 🗌 Unch	anged	Retrogressed	1

ATTENDING PHYSICIAN'S STATEMENT	OF DISABILITY	(Side two)
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its expected duration.		order, please describe the extent of the limitation and
Standing:		
Walking:		
Sitting:		
Lifting/carrying:		
Reaching/working overhead:		
Pushing:		
Pulling:		
Driving:		
Keyboard use/repetitive hand motion:		
If any other activities are limited, please specif	fy the activities and the limitations:	
If the patient's vision is impaired, please descr	ibe the extent of the impairment:	
Do you believe the patient is competent to end What is the psychiatric impairment (<i>if applicable</i> Inadequate information to make assess Essentially good functioning in all areas Slight difficulty in occupational function Moderate impairment in occupational fu Major impairment in several areaswor Inability to function in almost all areas.)? sment. s. Occupationally and socially effective ing, but generally functioning well. Has unctioning. Limited in performing some 	s some meaningful interpersonal relationships. coccupational duties.
Date patient became unable to work due to t	his impairment? Month	Day Year
		t?
		Telephone # FAX #
		Specialty:
Street Address:	City:	State: Zip Code:

Signature: ____

_____ Date signed: _____

Hartford Life Insurance Company Hartford Life and Accident Insurance Company

Sample Completed Long Term Disability Claim Form

			500	
			THE	
			HARTFORD	
			HARTFORD LIFE INSURANCE COMPANY	
			HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY	
			APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS	
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	rins appi	licatioi	a package is divided into four sections, as follows:	
	Section		Enclosed Children and the backward of the the second	
	Section	•	Employer's Statement - to be completed by the employer's authorized representative. Be sure to provide any necessary attachments (see Section K).	
	Section	le.	Information for Group Life Premium Waiver Benefits - to be completed by the	
	000000	10.	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	11	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	111	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.	
			EE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE ED APPLICATION TO YOUR HARTFORD BENEFIT MANAGEMENT SERVICE CENTER.	
	571-13 (Pri	nted in	U.S.A.)	
LC-4				
LC-4				



Employer's Statement

- 1. <u>Date employee became</u> <u>insured under this plan?</u> This is usually the day following completion of the Eligibility Waiting Period for the group policy. If the employee was a late enrollee, however, the effective date is the date the employee's Personal Health Statement was approved by The Hartford.
- 2. Information needed for withholding and reporting taxes. This information is important because it determines the amount of taxable wages and/or benefits that should be reported for the employee. The portion of the benefit funded by you is taxable.
- 3. <u>Last day employee actually</u> <u>worked?</u> This is the *actual* last day the employee worked, not the date through which earnings or sick pay were continued.
- 4. Complete this section if employee has Hartford Life Insurance.

HARTFORD	HAF HARTFORD LII					S Section I Employer's Statemen
To be Completed by the Employ						
This claim is for (Employee's Name)		Social Security			Date of Birth
Employee's Address (Street, City, S	John De	0 C.	001-02	-0003		6-1-49
Employee's Address (Sireer, City, 3		N ST., A	NUTOWO	u mo	010	· ·
A. Information About the Emplo		v 203 A	10910001	,	0100	
Company's Name						Group Policy Number
	ABC CO	•	* s			GLT-12345
Address (Street, City, State, Zip)						Telephone Number
	5 ABC	DR., AN	YTOWN,	MAO	1021	(413) 843-7777
Name and address of division whe	ere employee works	(if different from ab	ove)			Fax Number
						(413) 843-1111
B. Information About the Emplo Date employee was hired	Date <u>employee</u> b	acama insured ur	der this plan	What	was the	employee's regularly scheduled
			ider this plan	work v	veek?	40 hours per week
5-1-82. Was the employee's LTD insurance	re issued on the bas		ealth Statement	Second Second		If "Yes," attach copy.
and the second s						mation for Group Life Premium
Was the employee insured under			No Through	4	Wai	/er Benefits
If "Yes," please provide the inclus			mougn		Does th	e employee also have Group Life ce coverage with The Hartford?
Has the employee been terminate Reason:	ar ∐Yes MrNol	r res," date:				No If "Yes," provide the
				· .	followin	g information:
					Basic A	mount \$ 20,000
Was the employee on Qualified Fa	amily Leave when di	sability began?	🗌 Yes 🛛 🗹 N	No	Supple	mental Amount \$
Did LTD insurance continue while	on Family Leave?		🗌 Yes 🔽 N	ło	Effectiv	e Date of Group
Date Leave of Absence started ur	der Family Leave	Act				urance coverage
D. Information Needed for Withh Based on the employer/employee considered taxable? <u>100</u> %. E. Information About the Claim	premium contributio (See Section 7 of I	ns made over the RS Publication 15	-A for information	on on dete	rmining	he taxable percentage.)
Based on the employer/employee considered taxable? 100 %.	premium contributio (See Section 7 of II	ns made over the RS Publication 15 sibilities due to th	A for information	on on dete	rmining	he taxable percentage.)
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Based on the employer/employee considered taxable?	premium contributio (See Section 7 of II nployee's job respon at were the changes nent job on his or he	ns made over the RS Publication 15 sibilities due to th , and when were the r last day at work On that day, did	6-A for information the disabling cond they made? ? the employee wo	on on deter dition befor How lo ork a full da	rmining of e the em ng had t <u>10 Y</u> ay?	he taxable percentage.) ployee became totally disabled? he employee been in this job?
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Based on the employer/employee considered taxable? 100 %. E. Information About the Claim Were there any changes to the en \Box Yes \Box No If "Yes," white What was the employee's permar CLERK Last day employee actually works H_{-2} - \hat{f} ? Why did employee stop working? DIS 6 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 1 5 1 5 1 5 1 1 5 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 5 1 1 1 1 1 1 1 1 1 1	premium contributio (See Section 7 of II inployee's job respon at were the changes ment job on his or he ed <u>CLTTY</u> ers' Compensation? d initial report of illne ensation carrier	ns made over the RS Publication 15 sibilities due to th and when were I r last day at work On that day, did Yes ass or injury and a	-A for information the disabling condition they made?	dition befor How loo ork a full da low many H Is the e	e the em e the em ng had t <i>IOY</i> ay? nours we employee Yes yee is e	he taxable percentage.) ployee became totally disabled? he employee been in this job? EA2S re worked? So condition work related? No spected/did return to work Full time? Ves No
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Employer's Statement (Continued)

5. Information about the employee's salary. This information should be based on the policy's specific definition of Basic Monthly Earnings. If you record earnings as an hourly rate, please be sure to include the number of hours worked in a regular week.

Γ

6. Please note the request in Section K.

What is the na				nlovees?	Yes 🗆 N	lo	
	mpany have a rehire or retur ame and title of the manage	r we should con	tact if we identify	y a rehabilitation			
I. Informatio	on About the Employee's S	Salarv		10041 · · · · · · · · · · · · · · · · · · ·			-
Basic Salary c	or wage immediately prior t	o cessation of v	vork because of	f disability (exclu	de bonuses, overt	ime, pay, etc.)	
2000	Monthly	Weekly	🗆 Anı	nually	Hourly	# Hours	/Week
s this employ	ee eligible for salary contir No If "Yes," what is the w	eekly amount?	\$ <u>46/.53</u> \	When do benefi	ts begin?4	- 3-99	End? 10-3-9
Vill the emplo	yee file for Short Term or S No If "Yes," what is the w	State Disability b eekly amount?	enefits? \$\	When do benefi	ts begin?		End?
ist any other	sources of income to which	the employee	is entitled as a r	esult of this disa	ability:		
Information Check the iten occurrence:	About the Physical Aspe ns below that relate to the Not Applicable means the per Occasionally means the perso Frequently means the perso Continuously means the perso	employee's job berson does not p rson does the activit on does the activit	and complete th erform this activit vity up to 33% of y 34% to 66% of t	y. the time. the time. 6 of the time.		hese definition	s for the frequency
					of Occurrence		
Activity Standing Walking		N/A	Occasional 교	ly	Frequently		
Sitting Balancing Stooping Kneeling Crouching Crawling							
Reaching/	working overhead Use/Repetitive Hand Motion	Descri					Weight
ACTIVITY		Deach	puon			i i cquoiioj	
-							lbs.
Pushing		2					lbs.
Pushing Pulling				- · ·			lbs.
Pushing						*	
Pushing Pulling Ulfting Carrying Can the job be What are the	e performed by alternating s major tasks requiring the u				age of the emplo	vee's workday	lbs. lbs. lbs.
Pushing Pulling Uifting Carrying Can the job be What are the	major tasks requiring the u	se of one or bot			age of the emplo	yee's workday	lbs. lbs. lbs.
Pushing Pulling Ulfting Carrying Can the job be What are the	major tasks requiring the ut tasks.	se of one or bot			age of the emplo	yee's workday	
Pushing Pulling Ulfting Carrying Can the job be What are the	major tasks requiring the ut tasks.	se of one or bot			age of the emplo	yee's workday	lbs. lbs. lbs. lbs.
Pushing Pulling Lifting Carrying Can the job be What are the each of these	major tasks requiring the u tasks. டி.சடிடூரு வா	se of one or bot	h hands? Indic		ige of the emplo	yee's workday	that is spent on
Pushing Putling Lifting Carrying Can the job be What are the each of these J. Information	major tasks requiring the ut tasks.	se of one or bot	h hands? Indic.	ate the percenta			that is spent on
Pushing Pulling Pulling Lifting Carrying Carrying Can the job bee J. Information Can the job bee s it possible to if "Yes," explai	major tasks requiring the u tasks. KEQGORG n About the Job as it Rela a modified to accommodate o offer the employee assist in.	tes to the Disal the disability eit	h hands? Indic bility her temporarily	ate the percenta	? 🗌 Yes 🔽	No If "Yes," ex	that is spent on
Pushing Pulling Pulling Uting Carrying Carrying Carrying Carrying An the job be What are the leach of these def 'Yes,'' explain the job be si it possible to the 'rys,'' explain CRequired A Please attach the employe popies of the lise you have me fa Workers'	major tasks requiring the u tasks. KE4 GOAR n About the Job as it Rela a modified to accommodate o offer the employee assist	tes to the Disat the disability eit ance in doing the b description. ms for LTD or C ection forms. a similar docum amployee's filo r	h hands? Indic bility her temporarily s job (e.g., throu, Group Life Insure ient, attach a co elating to this di	ate the percenta or permanently gh the use of tec ance coverage, py of the docum sability, please	hnology or personal field of the second seco	No If "Yes," ex onal assistance; the enrollmen	ibs. ibs. <t< td=""></t<>
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Employee's Statement

7. Information about your <u>family</u>. This information helps determine whether dependent Social Security benefits might be payable.

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	APPLICATION FO	R LONG TERM DIS	SABILITY INCOME	BENEFITS Se	ction II
THE SAL	HAR	TFORD LIFE INSU	RANCE COMPAN	Y En	nployee's Statem
HARTFORD	HARTFORD LIF	E AND ACCIDENT	INSURANCE CO	MPANY	
To Be Completed by the Emp A. Information about you	ployee (BESURE	TO ANSWER ALL QUES	STIONS— FAILURE	TO DO SO MAY DELA	Y YOUR CLAIM)
Last name	First		Middle Initial	Social Security	V Number
×		•		101-0	
Address (Street)	JOHN	City	State/Province	001-00	2-0003
Telephone Number	s <i>T</i> .,	ANYTOWN	<i>m A</i>	010	121
(4/3) 843- Date of Birth (Month, Day, Year)	3344	Weight		Cia - la	
Date of Birth (Month, Day, Year)	Height	vveignt	Male Female	Single	Widowed Divorced
6-1-49	6'	180			
Your employer (include division, if an	oplicable)			Occupation	
ABC CO.		· · · · ·		CLERI	K
When your disability began, did yo	u have more than or	ne employer (includes	self-employment)?	Yes No. If "	Yes," please
provide the name, address and ph	none number of that	employer. Indicate th	e dates when you w	orked (or were self-e	employed).
Please indicate the extent of your f High School: 1 2 3 4	formal education (Cir	cle one) 9 10 11 (12)			
College: 1 2 3 4	1 0 7 0		Masters	Ph.D.	
Trade School:					
Briefly describe your past work ex	perience for the last	20 years (Begin with y	our most recent job.)	· · ·	
Job Title		Dul	ties		Years Worked
(2)		a			17
(a) CLERK		CLERICAL	· .		
(1)	1.1	A			10
(b) CLERK		CLERICAL	· · · · · · · · · · · · · · · · · · ·	-	
					v.
(c)				. ,	
· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·		. *	
(đ)		and in a solding upbat	ilitation to come at	oor kind of work?	
(d) Now, or at some time in the future	, would you be inter	ested in seeking rehat	pilitation to some oth	her kind of work?	
(d) Now, or at some time in the future ☑ Yes □ No			pilitation to some oth	ner kind of work?	
(d) Now, or at some time in the future ☑ Yes □ No Have you contacted your State De	epartment of Vocatio	onal Rehabilitation?			
(d) Now, or at some time in the future ☑ Yes □ No	epartment of Vocatio	onal Rehabilitation?			
(d) Now, or at some time in the future [✔] Yes ☐ No Have you contacted your State D ☐ Yes ☑ No If "Yes," plea	epartment of Vocatic ase include the name	onal Rehabilitation? e, address and telepho	ne number of your c		
(d) Now, or at some time in the future I Yes □ No Have you contacted your State Do □ Yes I No If "Yes," plea B. Information About your Famil	epartment of Vocatic ase include the name	onal Rehabilitation? e, address and telepho	ne number of your c		
(d) Now, or at some time in the future ∬ Yes □ No Have you contacted your State Do ○ Yes ☑ No If "Yes," plee B. Information About your Famil Spouse's Name (<i>Last, first</i>)	epartment of Vocatic ase include the name ly (required to determin	onal Rehabilitation? e, address and telepho	ne number of your c		
(d) Now, or at some time in the future ∬ Yes □ No Have you contacted your State Do ○ Yes ☑ No If "Yes," plee B. Information About your Famil Spouse's Name (<i>Last, first</i>)	epartment of Vocatic ase include the name ly (required to determin	onal Rehabilitation? e, address and telepho ne your eligibility for Soci	ne number of your c al Security Benefits)	counselor.	
(d) Now, or at some time in the future ∬ Yes □ No Have you contacted your State Do ○ Yes ☑ No If "Yes," plee B. Information About your Famil Spouse's Name (<i>Last, first</i>)	epartment of Vocatic ase include the name ly (required to determin	onal Rehabilitation? e, address and telepho	ne number of your c al Security Benefits)		
(d) Now, or at some time in the future	epartment of Vocatic ase include the name ly (required to determine Date of B	onal Rehabilitation? e, address and telepho ne your eligibility for Soci	ne number of your c al Security Benefits)	ounselor.	
(d) Now, or at some time in the future ✓ Yes → No Have you contacted your State Dr → Yes ✓ No If "Yes," plea B. Information About your Famil Spouse's Name (Last, first) DOE T Number 	epartment of Vocatic ase include the name ly (required to determine Date of B	onal Rehabilitation? , address and telepho ne your eligibility for Soci inth (Month, Day, Year) 3 - 1 5 - 5 - 5	ne number of your c al Security Benefits)	ounselor.	
(d) Now, or at some time in the future	epartment of Vocations include the name by (required to determine Date of B See 19? e and date of birth of	anal Rehabilitation? , address and telepho he your eligibility for Soci inth (Month, Day, Year) 3-15-5-5 each child	ne number of your c al Security Benefits)	ounselor.	ed? Retired?
(d) Now, or at some time in the future ✓ Yes □ No Have you contacted your State Dr □ Yes ✓ No If "Yes," plea B. Information About your Famil Spouse's Name (Last, first) DOE, JANJ Spouse's Social Security Number <u>000-00-00000</u> Do you have any children under A ✓ Yes □ No If "Yes," nam	epartment of Vocatic ase include the name ly (required to determine Date of B Age 19? e and date of birth of DOE JR.	onal Rehabilitation? , address and telepho ne your eligibility for Soci irth (Month, Day, Year) 3 - 1 5 - 5 5 each child 6 - 5 - 8 5	ne number of your c al Security Benefits)	ounselor.	
(d) Now, or at some time in the future ♥ Yes	epartment of Vocatic ase include the name ly (required to determin Date of B Age 19? e and date of birth of DOE, T.C.	onal Rehabilitation? , address and telepho re your eligibility for Soci inth (Month, Day, Year) 3-15-5-5 each child $6-5-8.5^{-1}$ of age)?	ne number of your c al Security Benefits)	ounselor.	
(d) Now, or at some time in the future ✓ Yes □ No Have you contacted your State Dr □ Yes ✓ No If "Yes," plea B. Information About your Famil Spouse's Name (Last, first) DOE, JANJ Spouse's Social Security Number <u>000-00-00000</u> Do you have any children under A ✓ Yes □ No If "Yes," nam	epartment of Vocatic ase include the name ly (required to determin Date of B Age 19? e and date of birth of DOE, T.C.	onal Rehabilitation? , address and telepho re your eligibility for Soci inth (Month, Day, Year) 3-15-5-5 each child $6-5-8.5^{-1}$ of age)?	ne number of your c al Security Benefits)	ounselor.	
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(d) Now, or at some time in the future ♥ Yes	epartment of Vocatic ase include the name ly (required to determin Date of B Age 19? e and date of birth of DOE, T.C.	onal Rehabilitation? , address and telepho re your eligibility for Soci inth (Month, Day, Year) 3-15-5-5 each child $6-5-8.5^{-1}$ of age)?	ne number of your c al Security Benefits)	ounselor.	
(d) Now, or at some time in the future ✓ Yes □ No Have you contacted your State Dr □ Yes ✓ No If "Yes," plea B. Information About your Famil Spouse's Name (Last, first) DOE, SAND DOE, SAND DOE, SAND DO -00-0000 Do you have any children with dit □ Yes □ No If "Yes," nam	epartment of Vocatic ase include the name ly (required to determin Date of B Age 19? e and date of birth of DOE, T.C.	anal Rehabilitation? , address and telepho ne your eligibility for Soci irth (Month, Day, Year) 3 - / 5 - 5 5 each child <u>6 - 5 - 8 5</u> f each child	ne number of your c al Security Benefits)	ounselor.	

Employee's Statement *(Continued)*

BACK PAIN When did you first notice them?	Have you	had this illness before? If so,	when?
-			WIGH:
SIX MONTHS AGO 2. For an injury, answer the following q	uestions:	2,	- the second
When, where and how did the injury occur	?		
10/98 At Home	Carrying al	adder.	
3. For Illness, Injury or Pregnancy, and Date you were first treated by a physician?	swer the following quest	OR. RALPH JON	JES
			NYTOWN, MA 01021
(Month Liay YAAR)		,	
Before you stopped working, did your con Ves V No If "Yes," explain.	dition require you to chang	ge your job, or the way you die	d your job?
What aspect of your condition made you u	inable to work?		
SITTING	the second second		·
Is your condition related to your occupation ☐ Yes ☑ No If "Yes," explain.	n?		
Have you filed, or do you intend to file a W	orkers' Compensation clai	m? 🗆 Yes 🗹 No	
D. Information About the Disability Last day you worked before the disability	Did you work a full day	? 🗹 Yes 🗆 No	Date you were first unable to work
4 2 9.9 (Month Day Year)	If "No" explain.		(Month Day Year)
Since that date, have you done any work?	Yes No	If you have not	returned to work, do you expect to?
If "Yes," please indicate dates worked, nar	ne of employer, and amou	ntearned.	me (date) Full time (date)
E. Information About Physicians and H	ospitals	omplate below!	
First medical attention for the current d	ospitals isability was given by <i>(cc</i>	Telephone	Specialty
First medical attention for the current d Doctor's Name	isability was given by <i>(cc</i>		
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Employee's Statement (Continued)

8. <u>Other income</u> Since the LTD benefit rate is affected by the amount of other income benefits you receive or are eligible to receive, it's important that you complete this section accurately.

F. Other Income				
Check the other income benefits (complete the information reques		eceiving, or are eligit	ble to receive during y	our disability
Source of Income	Amount(week /month)	Date Claim was filed	Date Payments began	Date Payments ende
Social Security/Retirement	\$/		· .	
Social Security/Disability	\$/		· · · ·	
Sick Pay or Salary Continuation	\$4521 Week		4-3-99	10-3-99
Income from Work	\$/		· .	·
Workers' Compensation	\$/	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
State Disability	\$/	· <u> </u>	· · ·	American data PARTO A
Pension/Retirement	\$/			
Pension/Disability	\$/		· · ·	
Short Term Disability	\$/		-	
Unemployment	\$/		Mar 1 10 22, 20 20 540	
No-Fault Insurance	\$/	· · ·		
Other (include Individual or Group Benefits)	\$/		-	
G. Information about Tax Withho				
Federal law requires us to withhold send a report to your employer at the amount withheld, if any, and your s dollar amount to be withheld per be	ne end of each calendar ye ocial security number. If yo	ar showing your name ou want us to withhold	e, total amount of bene I tax, please indicate o	fits paid to you, tota n the line below the

Employee's Statement (Continued)

H. Signature	
and am not eligib receive income of	of any source(s) of income reported above in Section F of this form, I certify by my signature that I have not te to receive any source of income, except for my Hartford Disability Income. Further, I understand that should I any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must The Hartford, immediately.
lump sum repaym	ty benefits greater than those which should have been paid, I understand that I will be required to provide a ent to the insurance company. The insurance company has the option to reduce or eliminate future disability to recover any overpayment balance that is not reimbursed.
Louisiana, Orego defraud any insur- materially false in benefit under an in	Il states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, n, and Virginia: A person commits a fraudulent insurance act if that person knowingly, and with intent to ance company or other person, either: (a) files an application for insurance or statement of claim containing any ormation, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a insurance policy. A fraudulent insurance act is a crime. The Hartford shall pursue prosecution of any ce act to the fullest extent of the law.
For residents of of claim or an app	Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement lication containing any false, incomplete or misleading information is guilty of a felony of the third degree.
containing any fall	New Jersey, Arkansas, New Mexico, and Louisiana: Any person who knowingly files a statement of claim se or misleading information is subject to criminal and civil penalties. Any person who includes any false or ation on an application for an insurance policy is subject to criminal and civil penalties.
company for the denial of insuran misleading infor	Colorado: It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, ce, and civil damages. Any insurance company or its agent who knowingly provides false, incomplete, or nation to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder egard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.
For residents o	Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other pplication for insurance or statement of claim containing any materially false information or conceals for
the purpose of m	sleading, information concerning any fact material thereto commits a fraudulent insurance act, which is ects a person to criminal and civil penalties.
the purpose of m a crime and subj For residents of Any person who	
the purpose of m a crime and subj For residents of Any person who and may be sub The statements or	ects a person to criminal and civil penalties. California: For your protection, California law requires the following to appear on this form: knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime ject to fines and confinement in state prison.
the purpose of m a crime and subj For residents of Any person who and may be sub	ects a person to criminal and civil penalties. California: For your protection, California law requires the following to appear on this form: knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime ject to fines and confinement in state prison.
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the purpose of m a crime and subj For residents of Any person who and may be sub The statements co knowledge and b	ects a person to criminal and civil penalties. California: For your protection, California law requires the following to appear on this form: knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime ject to fines and confinement in state prison. Intained in this application for Long Term Disability Income Benefits are true and complete to the best of my elief. California: For your protection, California law requires the following to appear on this form: hortained in this application for Long Term Disability Income Benefits are true and complete to the best of my elief. California: California law requires the following to appear on this form: hortained in this application for Long Term Disability Income Benefits are true and complete to the best of my elief. California: California law requires the following to appear on this form: hortained in this application for Long Term Disability Income Benefits are true and complete to the best of my elief. California: California law requires the following to a pay the best of the best of my hortained in this application for Long Term Disability Income Benefits are true and complete to the best of my elief. California: California law requires the following to a pay the best of

Authorization to Obtain Information

The employee completes and signs this section.

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, Medical Information Bureau, Inc., Heatth Claims Index, 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
JOHN DOE Insured's Name (Please print.)
6-1-49 (Date of Birth) 001-02-0003 (Social Security Number)
 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.
 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 further authorize The Hartford or its reinsurers to request a report from the Medical Information Bureau (MIB), which is an association of life insurance companies that operates the Health Claim Index (HCI) on behalf of subscriber insurers. I understand that The Hartford may also send a brief report to HCI. An HCI report includes the dates of claims filed for or by me, claim date of a loss and the names of companies to which claims were submitted, but does not contain medical information. Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my HCI file. If I question the accuracy of information in the file, I may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is Post Office Box 105, Essex Station, Boston, MA 02112,
telephone number (617) 426-3660.
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, Medical Information Bureau, Health Claim Index, 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.
\circ 1 \circ .
Signafure of Insured or Guardian Relationship to Insured (if signed by Guardian)
<u>6-2-99</u> Date
LC-4571-13 (7)

Attending Physician's Statement

The employee fills out the top section, and the employee's physician completes the remaining sections.

TTENDING PHYSICIAN'S STATEMENT OF DISABILITY				
ame of patient <u>JOHN OOE</u> Social Se	curity Number 001-0	2-0003 D.O.E	6-1-	+9
ddress of patient	UTAMIN 1	or Province	0103	
Employer's name (and division, if applicable) _ABC _Co.				
hereby authorize release of information on this form by the below amed physician for the purpose of claim processing.	Signed (Patient)	loe	Date:	5-2-99
o be completed by the Attending Physician (The patient is respo	nsible for the completio	on of this form wi	thout expense to	the Company.)
atient's condition is the result of: 🔲 Illness 🗹 Injury	Pregnancy	Height	v	/eight
pregnancy, what is the expected date of delivery? Month	Day	Year		
condition due to illness or an injury that is work related? $\hfill \square$ Yes	No No			
IAGNOSIS imary diagnosis: Hermiated Lumbar Ris	~ L 5		ICD-9 Code:	122.10
econdary diagnosis(es): LOW Back Pain			ICD-9 Code(s):	724.3
ubjective symptoms:				
est Results (list all results, or enclose test):				
est: Date:	Results:			
	Results:			
Physical examination findings:		NUMBER OF STREET, STREE		
·	·			
pregnancy, Indicate LMP date: Month Day	Year			
REATMENTS	· · · · · · · · · · · · · · · · · · ·			nd en
ate you first treated this patient: 2-5-99 Date you	irst treated this patient	for this condition:	2-5-99	
ate of onset of this condition: 10/98 Date of most r	ecent treatment:			
ow often has patient been seen/treated? Eveny two b			t office visit:	-5-98
as patient been referred to any other physician? Yes Yo				
ame and address:				0
· · · · · · · · · · · · · · · · · · ·	Sp	pecialty:		
ature of treatment for this condition:	· · · · ·			
as surgery been performed? IV Yes No If "Yes," Date: 4-	/3-99 Procedure:		CPT	Code:
As patient hospitalized for this condition? Yes No If "Yes				
ame and address of hospital(s): <u>UNIVERSITY NO</u>	· · · _	· · · · · · · · · · · · · · · · · · ·		
15 FIRST ST., I		A		
	ed 🗀 Unchanged			
C-4571-13	(8)			

Attending Physician's Statement (Continued)

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY (Side two)	
MPAIRMENT (the patient's ability to perform any of the following activities is limited by his/her disorder, pleas xpected duration.	e describe the extent of the limitation and its
tanding: NO MORE THAN 2HRS IN AN SHROAY	
Valking: NO MORE THAN 1/2 HR WITHOUT REST	
itting: NO MORE THAN 2 HRS IN AN BHR D	θŶ
ifting/carrying: NO MORE THAN 15 LOS	
Reaching/working overhead:	
Pushing:	
Pulling:	
Driving:	
eyboard use/repetitive hand motion:	
eyboard use/repetitive hand motion:	
(eyboard use/repetitive hand motion:	
	······································
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any other activities are limited, please specify the activities and the limitations:	hereof? 🗹 Yes 🗌 No
f any other activities are limited, please specify the activities and the limitations:	hereof? 🗹 Yes 🗖 No
f any other activities are limited, please specify the activities and the limitations:	hereof? 🗹 Yes 🗖 No
f any other activities are limited, please specify the activities and the limitations: the patient's vision is impaired, please describe the extent of the impairment: boyou believe the patient is competent to endorse checks and direct the use of the proceeds to that is the psychiatric impairment (<i>if applicable</i>)? Inadequate information to make assessment. Essentially good functioning in all areas. Occupationally and socially effective.	
f any other activities are limited, please specify the activities and the limitations: the patient's vision is impaired, please describe the extent of the impairment: yo you believe the patient is competent to endorse checks and direct the use of the proceeds t har is the psychiatric impairment (<i>il applicable</i>)? 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 n	eaningful interpersonal relationships.
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f any other activities are limited, please specify the activities and the limitations: f the patient's vision is impaired, please describe the extent of the impairment: by you believe the patient is competent to endorse checks and direct the use of the proceeds to that 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 n Moderate impairment in occupational functioning. Limited in performing some occupational induction in almost all areas. Inability to function in almost all areas. Date patient became unable to work due to this impairment? Month 4 f physical or psychiatric limitations exist, how long do you feel limitations will last? Uttending Physician's Name: ICALPH JONES, mO (Please print or type.) .cense No.	eaningful interpersonal relationships. onal duties. family, is unable to work. hay <u>3</u> Year <u>99</u> Telephone # (4/3) 843-000 - FAX # Specialty: <u>0/ЛТН0РЕ DICS</u>