HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

Section I **Employer's Statement -** to be completed by the employer's authorized representative. Be sure to provide any necessary attachments (see Section K).

I C. 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 fax or mail the completed application to:

The Hartford
Attn: Group LTD Claims
P.O. Box 14302
Lexington, KY. 40512-4302
Telephone: (800) 549-6514
Fax: (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.

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Fax or mail the completed application to:
The Hartford
P.O. Box 14302
Lexington, KY. 40512-4302
Fax Number: (866) 411-5613

HARTFORD LIFE INSURANCE COMPANY
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APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

Clear Form

THE HARTFORD

Section I - Employer's Section - 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)		Telephone Number: ( )

A. Information About the Employer

Company's Name:		Group Policy Number:
Address: (Street, City, State, Zip)	Telephone Number: ( )	Fax Number: ( )
Name and address of division where employee works: (if different from above)	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.

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

Was the employee insured under your prior LTD policy? ☐ Yes ☐ No If "Yes," please provide the inclusive date of coverage.
From _____ Through _____ Has the employee been terminated? ☐ Yes ☐ No If "Yes," date. _____
Reason:

Was the employee on Qualified Family Leave when disability began? ☐ Yes ☐ No Did LTD insurance continue while on Family Leave? ☐ Yes ☐ No Date Leave of Absence started under Family Leave Act: _____	Is the employee a union member? ☐ Yes ☐ No If Yes, name of union and local number:

C. Information for Group Life PremiumWaiver Benefits

Does the employee also have Group Life Insurance coverage with The Hartford? ☐ Yes ☐ No If "Yes," provide the following information: Basic Amount $_____ Supplemental Amount $_____ Dependent Amount $_____
Effective Date of Group Life Insurance coverage: _____

D. Information Needed for Withholding and Reporting Taxes

What percent of this employee's LTD benefits is taxable? _____%.
What percentage, if any, do you contribute towards the cost of the LTD premium?_____%
Does the employee contribute towards the cost of the LTD premium? ☐ Yes ☐ No.
If "Yes," is it on a ☐ Pre or ☐ Post Tax basis?

E. Information About the Claim

Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became totally disabled? ☐ Yes ☐ No If "Yes," what were the changes, and when were they made?

What was the employee's permanent job on his or her last day at work?	How long has the employee been in this job ?
Why did employee stop working?	Is the employee's condition work related? ☐ Yes ☐ No

Last day employee actually worked:	On that day, did the employee work a full day? ☐ Yes ☐ No If "No," how many hours were worked? _____
Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No If "Yes," send initial report of illness or injury and award notice.	Date employee is expected/did return to work: _____ Full time? ☐ Yes ☐ No

Name and address of your compensation carrier

F. Information About Your Pension Plan (Do not complete for maternity claim.)

Do you have a pension plan? ☐ Yes ☐ No If "Yes," what type? (Check as many as applicable)
☐ Defined contribution ☐ Profit Sharing ☐ Defined benefit ☐ 401 K ☐ Other (specify) _____

Is the employee eligible for your pension plan? ☐ Yes ☐ No If "No," why?	If eligible, does the employee participate? ☐ Yes ☐ No If "No," why?

If the employee is participating, when is he or she eligible for benefits under the plan? _____

At what point does the employee qualify for a full pension? _____

Is there a Disability Retirement Option available to this employee? ☐ Yes ☐ No

G. Information About Your Rehire or Return-to-Work Policies

Does your company have a rehire or return-to-work policy for disabled employees? ☐ Yes ☐ No
What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?

H. Information About the Employee's Salary

Basic Salary or wage immediately prior to cessation of work because of disability: (exclude bonuses, overtime, pay, etc.)
$_____ ☐ Annually ☐ Monthly ☐ Bi-Weekly ☐ Weekly ☐ Hourly Number of Hours/Week: _____

Is this employee eligible for salary continuation or Sick Pay?
☐ Yes ☐ No If "Yes," what is the bi-weekly amount? $_____ When do benefits begin? _____ End? _____

Will the employee file for Short Term or State Disability benefits?
☐ Yes ☐ No If "Yes," what is the weekly amount? $_____ When do benefits begin? _____ End? _____

List any other sources of income to which the employee is entitled as a result of this disability:

I. 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.

	Frequency of Occurrence			
Activity	**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.

_____ _____%
_____ _____%
_____ _____%

J. 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:

K. Required Attachments and Signature

Please attach a copy of the employee's job description.
If the employee contributes to the premiums for LTD or Group Life Insurance coverage, attach a copy of the enrollment form and/or copies of the last two Flexible Benefits Election forms.
If salary is based on a W-2, K-1, 1099, or a similar document, attach a copy of the document.
If you have medical information from the employee's file relating to this disability, please attach copies.
If a Workers' Compensation claim is filed, send initial report of injury or illness and award notice.
Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly.
Name of person completing this form (if this claim is approved for disability benefits, the benefit check will be sent to the employee with a copy to you).

_____ _____
Name (Please print or type) Title

_____ _____
Signature Date

Fax or mail the completed application to:
The Hartford
P.O. Box 14302
Lexington, KY. 40512-4302
Fax Number: (866) 411-5613

HARTFORD LIFE INSURANCE COMPANY
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APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

THE HARTFORD

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 Name: Middle Initial: | Date of Birth: | Social Security Number:

Address: (Street, City, State & Zip Code) | Gender: ☐ Male ☐ Female

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

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

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Occupation:

Your employer: (include division, if applicable)

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

Please indicate the extent of your formal education: (Check one)
☐ HS/GED ☐ Trade School/Certification Program ☐ AA/AS ☐ BA/BS ☐ Masters ☐ Doctorate ☐ Some college
☐ Other List all licenses, certifications, majors

Have you ever served in the military? ☐ Yes ☐ No

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

Dates Employed	Employer	Job Title	Describe Duties

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

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

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

Legal Spouse's Name: (Last, First)

Legal Spouse's Social Security Number: | Date of Birth: (Month/Day/Year) | Is your legal spouse employed? ☐ Yes ☐ No | Retired? ☐ Yes ☐ No

Do you have any children under Age 19? ☐ Yes ☐ No If "Yes," please provide the information requested below for each child.

Name: Date of Birth: Social Security Number:

Name: Date of Birth: Social Security Number:

Name: Date of Birth: Social Security Number:

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

Name: Date of Birth: Social Security Number:

Name: Date of Birth: Social Security Number:

C. Information About the Condition Causing Your Disability

1a. For illness, answer the following questions:

What were your first symptoms?

When did you first notice them? | Have you had this illness before? ☐ Yes ☐ No If so, when?

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

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

( ) Bathe (tub, shower, or sponge) ( ) Transfer from Bed to Chair

( ) Dress ( ) Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene.

( ) Toilet ( ) Feed yourself with food that has been prepared and made available to you.

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

Height: _____ **Weight:** _____

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

2. For an injury, answer the following questions:

When, where and how did the injury occur?

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

Date you were first treated by a physician? _____ (Month/Day/Year)

Name of Physician:

Address of Physician:

Before you stopped working, did your condition require you to change your job, or the way you did your job? ☐ Yes ☐ No
If "Yes," explain:

What aspect of your condition made you unable to work?

Is your condition related to 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

D. Information About the Disability

Last day you worked before the disability: _____ (Month/Day/Year)

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

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

Date you were first unable to work: _____ (Month/Day/Year)

If you have not returned to work, do you expect to? ☐ Yes ☐ No Part time _____ (date) Full time _____ (date)

E. Information About Physicians and Hospitals

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

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

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

Doctor's Name:	Telephone: ( ) Fax: ( )	Specialty:
Address: (Street, City, State & Zip)		Dates seen: **to**
Hospital:		
Address: (Street, City, State & Zip)		Dates of Confinement: **to**

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

E. Information About Physicians and Hospitals (Cont...)

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

Doctor's Name	Telephone ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates seen **to**
Hospital		
Address (Street, City, State, Zip)		Dates of Confinement **to**

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, Group, or Veteran's Benefits)	$_____ / _____			

G. Information about Tax Withholding

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

Section III

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To: Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, 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, and to communicate telephonically or electronically with The Hartford's representatives about, any and all of the following personal, private, 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 medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all 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 by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and/or leave request and/or request for accommodation. 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 restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); 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, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any 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, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) 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, respond to regulatory complaints, 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 Authorized Representative	Date (Valid for 2 years)	Relationship to Insured (*if signed by Authorized Representative*)

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries and their affiliates

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 Arizona, 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 Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject 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 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 benefit and 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

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

Please fax the completed form to:
Fax Number: 866-411-5613
The Hartford
P.O.Box 14302
Lexington, KY 40512-4302

ATTENDING PHYSICIAN'S STATEMENT - INITIAL REPORT

Clear Form

THE HARTFORD

To be completed by the Employee

Patient Name:	Date of Birth:	Insured ID Number:

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

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Patient's condition is the result of: ☐ Sickness ☐ Injury ☐ Pregnancy

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

Is condition due to illness or an injury that is related to: ☐ Work Activity ☐ Motor Vehicle Accident

Medical Conditions Impacting Activity

Primary condition: _____ ICD-9 Code: ☐ _____

ICD- 10 Code: ☐ _____

Secondary condition(s): _____ ICD-9 Code: ☐ _____

ICD-10 Code(s): ☐ _____

Subjective symptoms: _____

Objective Physical Findings (Please include office notes for date(s): _____ to _____

_____

Pertinent Test Results (list all results or attach test results):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Condition(s) Specific Medications, Dosage and Frequency:

_____

_____

Treatments

Date your patient reported stopping work: _____ Date of disability: _____ Expected Return to Work Date: _____

Date you first treated this patient: _____ Date you first treated this patient for this condition: _____

Date of reported onset of this condition: _____ Date of most recent treatment: _____

How often has patient been seen/treated for this condition? _____ Date of next office visit: _____

Current Treatment Plan: _____

_____

Has surgery been performed? ☐ Yes ☐ No Is surgery planned? ☐ Yes ☐ No If "Yes," Date: _____

Procedure: _____ CPT Code: _____

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

Name of Hospital: _____ Telephone Number of Hospital: (____) _____

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

Other Physician Name: _____ Phone Number: (____) _____ Specialty: _____

Other Physician Name _____ Phone Number: (____) _____ Specialty: _____

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Patient Name: Date of Birth: Insured ID Number:

Complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your medical findings and opinion, address the full range of restrictions/limitations at the time patient stopped working, reduced their work schedule or initially visited your office for this condition, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: _____

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent circle time for each section below	
				Hours at one time	Total hours/8 hours
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	☐	☐	☐	☐	
Kneel/crouch	☐	☐	☐	☐	
Climb	☐	☐	☐	☐	
Balance	☐	☐	☐	☐	
Drive	☐	☐	☐	☐	
Lift - Indicate weight in pounds		____ lbs.	____ lbs.	____ lbs.	.
Other Restrictions (if any)_____	☐	☐	☐	☐	
Hand Dominance: ☐ Right ☐ Left					
Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral					
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: _____

Current Status (Please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Additional Comments (If Necessary): _____

Does the patient have a psychiatric / cognitive impairment? ☐ Yes ☐ No If "Yes," please describe the extent of the impairment and its etiology: _____

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

Provider's Name: (please print or type)	EIN Number:	License Number:

Telephone Number: ( )	Fax Number: ( )	Degree:	Specialty:

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

Office Contact and Telephone Number:

Provider's Signature: _____ Date signed: _____