Fax or mail the completed application to:
The Hartford
P.O. Box 14869
Lexington, KY 40512-4869
Fax Number: (833) 357-5153

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

THE HARTFORD

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? ☐ Yes ☐ No 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 Disability? ☐ Yes ☐ No 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.
Select either majority of workday or sporadically.

Activity	Majority of workday (with standard breaks)		Sporadically throughout day	If sporadically circle time for each section below: Hours at one time	Total hours/8 hour
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

Can the job be performed alternating sitting and standing? ☐ Yes ☐ No

Activity	Never	Occasionally (1-33%)	Frequently (34-67%)	Constantly (68-100%)
Driving	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Bending at Waist	☐	☐	☐	☐
Kneeling/Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Climbing	☐	☐	☐	☐

Lift/Carry/Push/Pull: Task Description (Describe object moved and any mechanical assistance in the last column)					
Lifting		lbs.	lbs.	lbs.	
Carrying		lbs.	lbs.	lbs.	
Pushing/Pulling		lbs.	lbs.	lbs.	
Upper Extremity Activity (not load bearing)	**Specify right (R) or left (L) if not bilateral)**				**Describe task performed**
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

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 _____

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company, under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.

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P.O. Box 14869
Lexington, KY 40512-4869
Fax Number: 833-357-5153

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

THE HARTFORD

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:	Your employer: (include division, if applicable)	Occupation:
☐ Married ☐ Single ☐ Divorced ☐ Widowed		

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 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	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 Healthcare Provider? _____ (Month/Day/Year)

Name of Healthcare Provider:

Address of Healthcare Provider:

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 Healthcare Providers and Hospitals

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

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

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

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

E. Information About Healthcare Providers and Hospitals (Cont...)

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

Healthcare Provider'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: Disability/Retirement	$ _____ / _____			
Social Security: Widow's/Widower's	$ _____ / _____			
Sick Pay or Salary continuation	$_____ / _____			
Income from Work	$_____ / _____			
Workers' Compensation	$_____ / _____			
State Disability	$_____ / _____			
Pension: Disability/Retirement	$_____ / _____			
Public Employee/State Teacher: Retirement/Disability	$_____ / _____			
Short Term Disability	$_____ / _____			
Unemployment	$_____ / _____			
No-Fault Insurance	$_____ / _____			
Other (include individual Group Benefits or Veteran's Benefits)	$_____ / _____			

Are you paying for Medicare Part D? ☐ **Yes** ☐ **No** **If "Yes," please enter amount:** _____**.00.**

Signature - Please read the statement that applies to your state of residence and sign the bottom of the second 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, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, 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 Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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 information to obtain or amend insurance coverage or to make a 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, 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 Ohio: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

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

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.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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.

_____ _____

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.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local, and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford and its representatives, the following personal, private, or privileged information, records, or documents related to:

Insured's Name (Please Print)	Date of Birth	Employer/Policyholder's Name:

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 substance abuse, and behavioral or mental health (but excluding psychotherapy notes); 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 or other government 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(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as “My Information.”

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. Without limiting the foregoing, 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, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, grievance, alternative dispute resolution, 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, other audits or benefit program reviews; (ii) to administrators 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/program 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, reinsurance or analytical 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 or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud. I understand that My Information disclosed to The Hartford and re-disclosed to others could include information regarding alcohol and substance abuse, HIV/AIDS, other communicable diseases, and behavioral and mental health records.

(Continue to next page)

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my written revocation, if earlier, except as may be reasonably necessary to prevent or detect perpetration of a fraud, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself. I understand that if The Hartford is the administrator of my employer's self-insured disability program or leave program that my employer is entitled to receive my records without this Authorization. I understand that a revocation of this Authorization is not effective to the extent that any of my Record Holders or The Hartford has relied on this Authorization or to the extent that the Hartford has a legal right to contest a claim for benefits or to contest the policy. If I do not sign this Authorization, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in a delay or denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

NOTICE TO INFORMATION PROVIDERS:
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

Signature of Claimant or Legal Representative **Date**

Name and Relationship to Claimant *(if signed by Legal Representative)*

Form must be signed and dated.

Please fax the completed form to:
Fax Number: 833-357-5153
The Hartford
P.O. Box 14869
Lexington, KY 40512-4869
Email: GBInformationUpload@thehartford.com

Clear Form

Attending Physician's Statement – Initial

To be completed by the Provider (The patient is responsible for any expense related to the completion of this form)

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Condition

Patient's condition is a result of:
☐ Illness ☐ Injury ☐ Pregnancy

If illness or injury, is condition related to:
☐ Work Activity ☐ Motor Vehicle Accident ☐ Intentional/Self-Inflicted

If pregnancy, what is date of delivery? __/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

Condition onset: __/__/____ (MM DD YYYY)

Date you first treated this patient: __/__/____ (MM DD YYYY)

First day recommended out of work: __/__/____ (MM DD YYYY)

Office visit to complete this form: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

Projected return to work date: __/__/____ (MM DD YYYY)

Disabling Diagnosis(es) and Impact to Function

ICD-10 Code
Please provide most specific codes:

|__||__||__|.|__||__||__||__| and |__||__||__|.|__||__||__||__|

Description of corresponding symptoms _____

Please provide most specific code possible, one character per block, up to two code entries possible. Ex.: |X|#|#|.|#|#|#|#|

Co-Morbid Conditions with Impact to Diagnosis

☐ None ☐ Opioid Usage ☐ Psoriasis ☐ Mental Health
☐ Diabetes ☐ Heart Disease ☐ Asthma/Bronchitis ☐ Cognitive Impairment
☐ Hypertension ☐ Obesity ☐ Auto-Immune Disease
☐ COPD ☐ Arthritis ☐ Other _____

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

Treatment Plan

☐ Conservative treatment ☐ Bed Rest ☐ Palliative care ☐ Hospice Care

☐ Hospitalization Admittance date: __/__/____ (MM DD YYYY) Discharge date: __/__/____ (MM DD YYYY)

☐ Next/Another appointment Date: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

☐ Physical/Occupational therapy |__| times per week ☐ until __/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

☐ Surgery Date: __/__/____ (MM DD YYYY) CPT Code(s): |__||__||__||__||__| and |__||__||__||__||__|
Please provide most specific code possible, one number per block, up to two code entries possible. Ex.: |#|#|#|#|#|

☐ Referral to a specialist Type: _____ Contact Info: _____

Current Medications (related to condition or impacting function)

☐ None ☐ Over counter medications: _____

☐ Prescription medications Name(s): _____

☐ Impacting function? ☐ Yes ☐ No If yes, why? _____

☐ Chemotherapy ☐ Radiation Start Date: __/__/____ (MM DD YYYY) End Date: __/__/____ (MM DD YYYY)

Please fax the completed form to:
Fax Number: 833-357-5153
The Hartford
P.O. Box 14869
Lexington, KY 40512-4869
Email: GBInformationUpload@thehartford.com

Attending Physician's Statement – Initial

To be completed by the Provider (The patient is responsible for any expense related to the completion of this form)

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Level of Functionality (Based upon your medical findings and opinion, address the full range of your patient's abilities. We will conclude that there are no restrictions on function unless specified below.)

Expected duration of any restriction(s) or limitation(s) listed below THROUGH __/__/____ (MM/DD/YYYY)

In a workday the patient is able to: (select either Continuous or Intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent, enter time for each section below	
				Hours at one time	Total hours in a workday
Sit	☐	or	☐	|___|	|___|
Stand	☐	or	☐	|___|	|___|
Walk	☐	or	☐	|___|	|___|

Key: C = Continuously (5.5 – 8 hours) F = Frequently (2.5 – 5.5 hours) O = Occasionally (up to 2.5 hours) N = Never

Activity Ability	C	F	O	N	Activity Ability	Right/Left	C	F	O	N
☐ Drive	☐	☐	☐	☐	☐ Squat / Kneel		☐	☐	☐	☐
☐ Weight bearing	☐	☐	☐	☐	Hand Dominance	☐ R ☐ L				
☐ Climb	☐	☐	☐	☐	☐ Fine Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐ Gross Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Max lift	___LBS	___LBS	___LBS	___LBS	☐ Reach above shoulder	☐ R ☐ L	☐	☐	☐	☐
☐ Max Carry	___LBS	___LBS	___LBS	___LBS	☐ Reach below shoulder	☐ R ☐ L	☐	☐	☐	☐

Completed or Planned Diagnostic Tests, Labs and Imaging (related to the disabling diagnosis)

Completed: ☐ X-ray __/__/____ (MM/DD/YYYY) ☐ MRI __/__/____ ☐ CT __/__/____ ☐ EKG __/__/____

☐ ECHO __/__/____ ☐ EMG __/__/____ ☐ Lab Work __/__/____

Findings of completed tests: ☐ No significant findings ☐ Confirmed diagnosis

Planned: ☐ X-ray ☐ MRI ☐ CT ☐ EKG ☐ ECHO ☐ EMG ☐ Lab Work Scheduled date __/__/____ (MM/DD/YYYY)

Provider Details

Provider Name: _____
Specialty: _____
EIN Number: _____
License Number: _____

Email: _____
Phone: (___) ___-____
Fax: (___) ___-____

Provider Signature: _____

Date: __/__/____ (MM/DD/YYYY)

Please fax the completed form to:
Fax Number: 833-357-5153
The Hartford
P.O. Box 14869
Lexington, KY 40512-4869
Email: GBInformationUpload@thehartford.com

Mental Health Attending Physician's Statement

TO BE COMPLETED BY THE PROVIDER

(The patient is financially responsible for this form)

Patient Last Name: _____ Patient First (or Preferred) Name: _____ Date of Birth: _ _/_ _/_ _ _ _ Claim ID Number: _____

Provider Name: _____ Provider Specialty: _____ Phone: _____ Fax/Email: _____

Please provide all medical records regarding your treatment of the patient for the impairment reported within this report form.

Is the condition related to environmental and/or interpersonal issues in his/her workplace? ☐ Yes ☐ No

If Yes, explain: _____

If Yes, can he / she perform the same job at a different location/employer? ☐ Yes ☐ No

If Yes, as of what date? _ _/_ _/_ _ _ _
MM DD YYYY

Are these issues causing disincentive to return to work with the current employer? ☐ Yes ☐ No

Diagnosis

Primary Condition _____ DSM or ICD Code |__||__||__|.|__||__||__||__|

Secondary Condition _____ DSM or ICD Code |__||__||__|.|__||__||__||__|

Current Self-Reported Symptoms _____

_____

Current Mental Status Examination

Examination Date _ _/_ _/_ _ _ _
MM DD YYYY

Category	Description				
Appearance	☐ Well Groomed	☐ Disheveled	**If different than baseline, explain:** _____		
Attitude	☐ Cooperative	☐ Guarded	☐ Suspicious	☐ Uncooperative	☐ Belligerent
Speech	☐ Normal	☐ Halted	☐ Pressured	☐ Slurred	☐ Incoherent
Thought Process	☐ Logical/Coherent	☐ Tangential	☐ Circumstantial	☐ Flight of Ideas	☐ Perseveration
Mood	☐ WNL	☐ Depressed	☐ Anxious	☐ Irritable	☐ Euphoric
Affect	☐ Congruent	☐ Incongruent	☐ Blunted	☐ Flat	☐ Labile
Insight into Illness	☐ Absent	☐ Fair	☐ Good		
Psychomotor Activity	☐ WNL	☐ Agitation	☐ Retardation		
Reasoning and Judgment	☐ WNL	☐ Impaired			
Attention	☐ Intact	☐ Impaired	☐ Mild	☐ Moderate	☐ Severe
Concentration	☐ Intact	☐ Impaired	☐ Mild	☐ Moderate	☐ Severe
Memory	☐ Intact	☐ Impaired	☐ Mild	☐ Moderate	☐ Severe

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Mental Health Attending Physician's Statement

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Patient Last Name: _____ Patient First (or Preferred) Name: _____ Date of Birth: _ _/_ _/_ _ _ _ Claim ID Number: _____

Current Mental Status Examination (continued)

Please identify how attention, concentration and/or memory impairments are being measured.

_____

_____

Additional observed symptoms (clinical presentation, frequency) _____

_____

Indicate how this is a change from the patient's baseline. If the condition is chronic or long term, what and when did change occur? _____

_____

Activities of Daily Living – Please provide input on the patient's current ability to perform the following:

The patient is currently capable of performing: ☐ Volunteer work ☐ Less demanding job ☐ Attending school ☐ No work in any capacity ☐ Self-employed

Significant weight/appetite change	☐ Yes ☐ No	Pounds gained _____ Pounds lost _____	Time period _____
Sleep disturbances	☐ Yes ☐ No	Describe _____	
Socialization	☐ Yes ☐ No	Describe _____	
Household chores	☐ Yes ☐ No	Describe _____	
Routine shopping	☐ Yes ☐ No	Describe _____	
In your opinion, is the patient competent to endorse checks, and direct the user of proceeds thereof?	☐ Yes ☐ No	Describe _____	
Drivers or operates a vehicle	☐ Yes ☐ No	Describe _____	
Caring for self/others	☐ Yes ☐ No		

Are the impairments impacting the patient's overall global functioning? If so, please explain.

_____

Additional comments on ability to complete daily activities: _____

_____

_____

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Mental Health Attending Physician's Statement

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Patient Last Name: _____ Patient First (or Preferred) Name: _____ Date of Birth: __/__/____ Claim ID Number: _____

Functionality

Are you recommending the patient stop working due to their current symptoms? ☐ Yes ☐ No

If Yes, Begin Date: __/__/____ (MM DD YYYY)

Are the symptoms of such severity to preclude the patient from social / occupational functioning? ☐ Yes ☐ No

If Yes, when did the symptoms become severe enough to preclude social / occupational functioning? __/__/____ (MM DD YYYY)

If Yes, what work activities are impaired and how? _____

_____

What is the return to work date you have discussed with the patient? __/__/____ (MM DD YYYY) ☐ Full-time ☐ Part-time

If Part-time, please specify: Hours per day _____ Days per week _____

What date will the patient be able to increase to full time? __/__/____ (MM DD YYYY)

If appropriate, provide examples of accommodations that would allow the patient to return to work:

_____

_____

What are the patient's current abilities? What type of work can the patient perform?

_____

_____

Additional comments: _____

_____

Treatment

Date of onset of disability __/__/____ (MM DD YYYY) Date you first treated the patient for any condition __/__/____ (MM DD YYYY)

Date of onset of this condition __/__/____ (MM DD YYYY) Date you first treated the patient for this condition __/__/____ (MM DD YYYY) Frequency of treatment _____

List of relevant treatment dates _____

Date of last office visit __/__/____ (MM DD YYYY) Date of next office visit __/__/____ (MM DD YYYY)

Has the patient been referred to any other mental health providers/physicians? ☐ Yes ☐ No

If Yes, please provide the following information:

Provider Name _____ Phone: (___)___-____

Provider Address _____

Are you coordinating care with this provider? ☐ Yes ☐ No

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Mental Health Attending Physician's Statement

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(The patient is financially responsible for this form)

Patient Last Name: _____ Patient First (or Preferred) Name: _____ Date of Birth: __/__/____ Claim ID Number: _____

Treatment (continued)

Was the patient hospitalized or treated at a higher level of care for this condition? ☐ Yes ☐ No

If Yes, please provide information about any higher level of care:

Inpatient

Hospital/Facility Name _____ Phone: (___) ___-____

Admission date __/__/____ (MM DD YYYY) Discharge date __/__/____ (MM DD YYYY) Reason for inpatient admission _____

Partial Hospital/Day Treatment/IOP

Hospital/Facility Name _____ Phone: (___) ___-____

Admission date __/__/____ (MM DD YYYY) Discharge date __/__/____ (MM DD YYYY) Days per week _____ Hours per day _____

Residential

Hospital/Facility Name _____ Phone: (___) ___-____

Admission date __/__/____ (MM DD YYYY) Discharge date __/__/____ (MM DD YYYY) Days per week _____ Hours per day _____

Medication (dose, change, date of change) _____

Response to medication (including any side effects) _____

Status (please check one) ☐ In remission ☐ Improved ☐ Unchanged ☐ Retrogressed

Please provide a description of the most significant recent improvement and / or decompensation

Provider Information

Provider Name: _____ License Number: _____

Specialty: _____ Degree: _____ Phone: (___) ___-____

Address: _____ Fax: (___) ___-____

Email: _____

Office Contact: _____ Contact Phone: (___) ___-____

Provider Signature: _____ Date: __/__/____ (MM DD YYYY)