

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



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: GLT-922246	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," attach copy.		
Was the employee insured under your prior LTD policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the inclusive date of coverage. From _____ Through _____ Has the employee been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," date. _____		
Reason: _____		
Was the employee on Qualified Family Leave when disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No Did LTD insurance continue while on Family Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Leave of Absence started under Family Leave Act: _____		Is the employee a union member? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No.
If "Yes," is it on a <input type="checkbox"/> Pre or <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Last day employee actually worked:	On that day, did the employee work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," how many hours were worked?	_____
Has a claim been filed with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date employee is expected/did return to work: _____	
If "Yes," send initial report of illness or injury and award notice. Full time? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what type? (Check as many as applicable)		
<input type="checkbox"/> Defined contribution <input type="checkbox"/> Profit Sharing <input type="checkbox"/> Defined benefit <input type="checkbox"/> 401 K <input type="checkbox"/> Other (specify) _____		
Is the employee eligible for your pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," why?	If eligible, does the employee participate? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	or <input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Stand	<input type="checkbox"/>	or <input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Walk	<input type="checkbox"/>	or <input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending at Waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling/Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Lift/Carry/Push/Pull: Task Description (Describe object moved and any mechanical assistance in the last column)

Lifting	<input type="checkbox"/>				
Carrying	<input type="checkbox"/>				
Pushing/Pulling	<input type="checkbox"/>				

Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral) Describe task performed

Fine manipulation (fingering, keyboard)	<input type="checkbox"/>				
Gross manipulation (grip/grasp, handle)	<input type="checkbox"/>				
Reach (extend arms) above shoulder	<input type="checkbox"/>				
Reach (extend arms) below shoulder at desk or workbench level	<input type="checkbox"/>				

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

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APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS



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:	<input type="checkbox"/> Male <input type="checkbox"/> 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:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Your employer: (include division, if applicable)	Occupation:
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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?	Retired?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

(<input type="checkbox"/>) Bathe (tub, shower, or sponge)	(<input type="checkbox"/>) Transfer from Bed to Chair
(<input type="checkbox"/>) Dress	(<input type="checkbox"/>) Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene.
(<input type="checkbox"/>) Toilet	(<input type="checkbox"/>) 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?	Name of Healthcare Provider:
(Month/Day/Year)	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: ()	Specialty:
	Fax: ()	
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: ()	Specialty:
	Fax: ()	
Address: (Street, City, State & Zip)	Dates seen: to	

Hospital:

Address: (Street, City, State & Zip)	Dates of Confinement: to
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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 ()	Specialty
	Fax: ()	

Address (Street, City, State, Zip)	Dates seen to
Hospital	

Address (Street, City, State, Zip)	Dates of Confinement to
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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.

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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.

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.

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.

(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.

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: If illness or injury, is condition related to: If pregnancy, what is date of delivery?

<input type="checkbox"/> Illness	<input type="checkbox"/> Injury	<input type="checkbox"/> Work Activity	<input type="checkbox"/> Motor Vehicle Accident	__ / __ / __ -	<input type="checkbox"/> Actual
<input type="checkbox"/> Pregnancy		<input type="checkbox"/> Intentional/Self-Inflicted		MM DD YYYY	<input type="checkbox"/> Estimated

Condition onset: __ / __ / __ - Date you first treated this patient: __ / __ / __ -

First day recommended out of work: Office visit to complete this form: Projected return to work date:

__ / __ / __ -	MM DD YYYY	<input type="checkbox"/> In Person	__ / __ / __ -
MM DD YYYY		<input type="checkbox"/> Telemedicine	MM DD YYYY

Disabling Diagnosis(es) and Impact to Function

ICD-10 Code

Description of corresponding symptoms

Please provide most specific codes:

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

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

<input type="checkbox"/> None	<input type="checkbox"/> Opioid Usage	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma/Bronchitis	<input type="checkbox"/> Cognitive Impairment
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Obesity	<input type="checkbox"/> Auto-Immune Disease	In your opinion is the patient competent to endorse checks and direct the use of proceeds?
<input type="checkbox"/> COPD	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Treatment Plan

Conservative treatment Bed Rest Palliative care Hospice Care

Hospitalization Admittance date: __ / __ / __ - Discharge date: __ / __ / __ -

Next/Another appointment Date: __ / __ / __ - In Person Telemedicine

Physical/Occupational therapy |__| times per week until __ / __ / __ - Actual Estimated

Surgery Date: __ / __ / __ - 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: __ / __ / __ - End Date: __ / __ / __ -

MM DD YYYY MM DD YYYY

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Please fax the completed form to:
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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	<input type="checkbox"/>	or <input type="checkbox"/>	<u> </u>	<u> </u>
Stand	<input type="checkbox"/>	or <input type="checkbox"/>	<u> </u>	<u> </u>
Walk	<input type="checkbox"/>	or <input type="checkbox"/>	<u> </u>	<u> </u>

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
<input type="checkbox"/> Drive	<input type="checkbox"/> Squat / Kneel		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/> Weight bearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hand Dominance	<input type="checkbox"/> R <input type="checkbox"/> L				
<input type="checkbox"/> Climb	<input type="checkbox"/> Fine Manipulation	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/> Bend	<input type="checkbox"/> Gross Manipulation	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/> Max lift	<u> </u> LBS	<u> </u> LBS	<u> </u> LBS	<u> </u> LBS	<input type="checkbox"/> Reach above shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Max Carry	<u> </u> LBS	<u> </u> LBS	<u> </u> LBS	<u> </u> LBS	<input type="checkbox"/> Reach below shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Completed: X-ray / / MRI / / CT / / EKG / /
 MM DD YYYY MM DD YYYY MM DD YYYY MM DD YYYY

ECHO / / EMG / / Lab Work / /
 MM DD YYYY MM DD YYYY MM DD YYYY

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: _____

Email: _____

Specialty: _____

Phone: (____) ____ - ____

EIN Number: _____

Fax: (____) ____ - ____

Provider Signature: _____

Date:

 / /
 MM DD YYYY

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

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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 Attending school Self-employed
 Less demanding job No work in any capacity

Significant weight/appetite change Yes No Pounds gained _____ Time period _____
Pounds lost _____

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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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