



Hartford Life

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

APPLICATION FOR DISABILITY INCOME BENEFITS

This application is divided into four sections, as follows:

- Section I Administrator's Statement** – to be completed by the Administrator.
- Section II Insured's Statement** – to be completed by the Insured who is applying for Disability benefits. The Insured's Statement and the attached Authorization to Release Information must both be completed, signed and dated (pages 3 & 5). Proof of earnings must also be provided, as well as proof of actively at work status. * (See section II & III).
- Section III Employer's Statement** – to be completed by the employer's authorized representative. Self-employed persons should complete this section. Be sure to provide any necessary attachments.
- Section IV Attending Physician's Statement** – to be completed by the physician who is treating the Insured at time of disability.

*The Definitions of Actively at Work and of Earnings can be found in your Certificate

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED TO AVOID
ANY DELAY IN PROCESSING YOUR CLAIM. FORWARD THE COMPLETED
APPLICATION TO YOUR ADMINISTRATOR.



APPLICATION FOR DISABILITY INCOME BENEFITS

For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, Oregon and Virginia: A person commits a fraudulent insurance act if that person knowingly and with intent to defraud any insurance company or other person either (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or benefit under an insurance policy. A fraudulent insurance act is a crime. The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

For residents of New Jersey, Arkansas, New Mexico and Louisiana: Any person who knowingly files a statement of claim containing 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 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement or claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

For residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.



APPLICATION FOR DISABILITY INCOME BENEFITS

Hartford Life
Disability Claims
P.O. Box 2993
Hartford, CT 06104-2993
Toll Free: 888-232-5340

THIS FORM IS TO BE COMPLETED BY THE INSURED PERSON
(FAILURE TO ANSWER ALL QUESTIONS MAY DELAY YOUR CLAIM)

Section I This section is to be completed by Administrator Of Insurance Plan

Name of Insured: Profession or Occupation:
Effective Date of Insurance: Effective date of change in coverage: Policy Number: Plan/Option Number: Premiums Paid to Date:
Name Of Group: Elimination Period: Benefit Maximum:
Date: Signed for Administrator by: Administrator Telephone Number:

Section II This section is to be completed by Claimant

Personal Information
Last Name: First Name: M.I.: SSN:
Address (Street): City: State/Province: Zip:
Telephone #: Date Of Birth: (Month, Day, Year) Male or Female? Married or Single?
[] Male [] Female [] Married [] Single

Medical Information

State fully the nature of your disability: (Advise which duties of your occupation you are unable to perform.)

For Illness, answer the following questions:

What were your first symptoms?
When did you first notice them? Have you had this illness before? If so, when?

For an Injury, answer the following questions:

When, where and how did the injury occur?

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

Name of Physician: Telephone Number: Date you were first treated by a Physician?
Address of Physician (Street, City, State & Zip) Fax Number: Are you still seeing this Physician? (Yes/No)
Is your condition related to your occupation? [] Yes [] No If "Yes", explain.
(Please check one)
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. (Please check one)

Have you filed, or do you intend to file a Workers' Compensation Claim? [] Yes [] No If "Yes", Please give name & address of Workers' Compensation Carrier.

Information about the Disability

Last date you worked before the disability. (Month, Day, Year) Date you were first unable to work. Since that date, have you done any work? [] Yes [] No
If "Yes" please indicate dates worked, name of employer and amount earned.
If you have not returned to work, do you expect to? [] Yes [] No [] Part-time (Date) [] Full-time (Date)
Occupation: License# (if Licensed Professional) License Status:
Basic Salary or Wage \$ [Monthly or Weekly?] (See Section III) Normal work hours per week: Current Work Status (Please check one)
[] Full-time [] Part-time [] Retired

Signature

The statements contained in this application for Disability Income Benefits are true and complete to the best of my knowledge and belief. I understand that should I perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately.

Signature of the Insured: Date:

APPLICATION FOR DISABILITY INCOME BENEFITS
(Altering or failure to sign this form may delay your claim)

Authorization to Obtain and Release Information

- TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies;
- Any employer, group policyholder, contract holder or insurer, benefit plan administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions; or
- Any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize you to release and send to: (i) Hartford Life Insurance Company, Hartford Life & Accident Insurance Company or (ii) Hartford Life Insurance Company representatives, a complete copy of any and all of the following information, records or documents relative to

_____ Insured's Name (*Please print*)

_____ (Date of Birth) _____ (Social Security Number)

1. Any and all medical information, including x-ray films, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits.
2. Work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including, but not limited to, credit reports and credit applications; other financial information, e.g., bank records; business transactions of any kind or description, including billing, invoices or payment records of any kind; and academic transcripts.
3. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record.

I understand that the information obtained by use of the Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by Hartford Life Insurance Company to any person or organization EXCEPT to reinsuring companies or their representatives, The Index System, physicians who have treated me, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required, or as I may further authorize, or as may be necessary to prevent or to detect the perpetration of a fraud.

I know that I may request to receive a copy of this Authorization. This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

Signature of Insured or Guardian

Relationship to Insured (if signed by Guardian)

Date

DISABILITY INCOME BENEFITS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

To be Completed by the Insured

Name of Patient _____ Social Security Number _____ D.O.B _____

Address of patient _____
Street City State or Providence Zip Code or Postal Code

Group Name _____ Policy Number _____

I hereby authorize release of information on this form by the below named Signed (Patient) physician for the purpose of claim processing. Date: _____

To be Completed by the Attending Physician (The patient is responsible for the completion of this form without expense to the Company.)

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

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

Is condition due to an illness or an injury that is work related? [] Yes [] No Height _____ Weight _____

DIAGNOSIS

Primary Diagnosis _____ ICD-9 Code: _____

Secondary Diagnosis(es) _____ ICD-9 Code: _____

Subjective Symptoms: _____

Test Results (list all results, or enclose test):

Test _____ Date _____ Results _____

Test _____ Date _____ Results _____

Physical examination findings: _____

Height _____ Weight _____ If pregnancy, indicate LMP date: Month _____ Day _____ Year _____

TREATMENTS

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

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

How often has patient been seen/treated: _____ Date of next office visit: _____

Has patient been referred to any other physician? [] Yes [] No If "Yes," Date(s) _____

Name and Address: _____

Specialty: _____

Nature of treatment for this condition (including medications): _____

Was surgery performed? [] Yes [] No If "Yes," Date _____ Procedure: _____ CPT Code: _____

Physical therapy [] Yes [] No

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

Name and Address of Hospital(s): _____

Progress (please check one): [] Recovered [] Improved [] Unchanged [] Retrogressed

DISABILITY INCOME BENEFITS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY (continued)

IMPAIRMENT

If the patient's ability to perform any of the following activities is limited by his/her disorder, please describe the extent of the limitation and its expected duration.

Standing: _____

Walking: _____

Sitting: _____

Lifting/Carrying: _____

Reaching/working overhead: _____

Pushing: _____

Pulling: _____

Driving: _____

Keyboard use / repetitive hand motion: _____

If any other activities are limited, please specify the activities and the limitations: _____

If the patient's vision is impaired, please describe the extent of the impairment: _____

Do you believe the patient is competent to endorse checks and direct use of the proceeds thereof? Yes No

What is the psychiatric impairment (if applicable)?

- Inadequate information to make assessment.
- Essentially good functioning in all areas. Occupationally and socially effective.
- Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
- Moderate impairment in occupational functioning. Limited in performing some occupational duties.
- Major impairment in several areas--work, family relations. Avoidant behavior, neglects family, is unable to work.
- Inability to function in almost all areas.

Date patient became unable to work due to this impairment? Month _____ Day _____ Year _____

If physical or psychiatric limitations exist, what is anticipated release date for return to work? _____

Attending Physician's Name: _____ Telephone # () _____

License No. _____ Fax # () _____

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

Street Address _____ City _____ State _____ Zip Code _____

Signature _____ Date Signed _____