

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: 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? Was the employee insured under your prior LTD policy? From Through Has the employee been terminated? Reason: Was the employee on Qualified Family Leave when disability began? Did LTD insurance continue while on Family Leave? Date Leave of Absence started under Family Leave Act: Is the employee a union member? If Yes, name of union and local number:

C. Information for Group Life Premium/Waiver Benefits

Does the employee also have Group Life Insurance coverage with The Hartford? 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? 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? 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? Last day employee actually worked: On that day, did the employee work a full day? If "No," how many hours were worked? Has a claim been filed with Workers' Compensation? Date employee is expected/did return to work: Full time? 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? Defined contribution Profit Sharing Defined benefit 401 K Other (specify) Is the employee eligible for your pension plan? If eligible, does the employee participate? 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?

**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		lbs.	lbs.	lbs.
Carrying		lbs.	lbs.	lbs.
Pushing/Pulling		lbs.	lbs.	lbs.
<b>Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral</b>				
Fine manipulation (fingering, keyboard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gross manipulation (grip/grasp, handle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach (extend arms) above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach (extend arms) below shoulder at desk or workbench level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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 \_\_\_\_\_

Please fax or mail the completed application to:

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**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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:
When your disability began, did you have more than one employer (includes self-employment)? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> HS/GED <input type="checkbox"/> Trade School/Certification Program <input type="checkbox"/> AA/AS <input type="checkbox"/> BA/BS <input type="checkbox"/> Masters <input type="checkbox"/> Doctorate <input type="checkbox"/> Some college <input type="checkbox"/> Other List all licenses, certifications, majors _____				
Have you served in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Briefly describe your past work experience for the last 20 years (Begin with your most recent job.)				
<b>Dates Employed</b>	<b>Employer</b>	<b>Job Title</b>	<b>Duties</b>	
Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you contacted your State Department of Vocational Rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any children under Age 19? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____
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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**

<b>First medical attention for the current disability was given by (complete below)</b>		
Healthcare Provider's Name:	Telephone: ( ) Fax: ( )	Specialty:
Address: (Street, City, State & Zip)		Dates seen: _____ to _____
<b>List all Healthcare Providers and Hospitals you have seen for this condition (attach separate sheet, if needed)</b>		
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.

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 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.