

Please return to:  
CBIA Insurance Operations  
350 Church Street, Hartford, CT 06403  
fax: 860-278-0883

**HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

**APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS**

This application package is divided into four sections, as follows:

- Section 1    Employer's Statement** - to be completed by the **employer's** authorized representative.
- Section II    Employee's Statement** - to be completed by the **employee** who is applying for Short Term Disability benefits.
- Section III    Authorization to Obtain Information** - to be signed by the **employee**.
- Section IV    Attending Physician's Statement** - to be completed by the physician who is treating the **employee**.

**PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO YOUR HARTFORD BENEFIT MANAGEMENT SERVICE CENTER.**

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS  
**HARTFORD LIFE INSURANCE COMPANY**  
**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

**Section 1**  
**Employer's Statement**

**To be Completed by the Employer**

This claim is for ( <i>Employee's Name</i> )	Social Security Number	Date of Birth
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Employee's Address (*Street, City, State, Zip*)

**A. Information About the Employer**

Company's Name <b>CBIA Service Corp.</b>	Group Policy Number <b>GRH-703586</b>
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Address (*Street, City, State, Zip*)

Name and address of division where employee works (*if different from above*)

**B. Information About the Employee**

Date employee was hired	What was the employee's regularly scheduled work week? Hours per Week _____
Date employee became insured under this plan	Scheduled workdays M-F _____ Other _____

**IS EMPLOYEE ENROLLED IN THE HARTFORD'S LONG TERM DISABILITY PLAN?**  Yes  No  
**IF "YES," EFFECTIVE DATE** \_\_\_\_\_

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

Was the employee insured under your prior STD policy?  Yes  No  
 If "Yes," please provide the inclusive date of coverage. From \_\_\_\_\_ Through \_\_\_\_\_

Was the employee on Qualified Family Leave when disability began?  Yes  No  
 Did STD & LTD insurance continue while on Family Leave?  Yes  No  
 Date Leave of Absence started under Family Leave Act \_\_\_\_\_

**C. Information Needed for Withholding and Reporting Taxes**

Based on the employer/employee premium contributions made over the last 3 years, what percentage of the STD \_\_\_\_\_ % LTD \_\_\_\_\_ % benefit is considered taxable? (*See Section 7 of IRS Publication 15-A for information on determining the taxable percentage.*)

**D. Information About the Claim**

What was the employee's permanent job on his or her last day at work? (*Please attach a copy of the employee's job description.*)

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? _____
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Why did employee stop working?	Is the employee's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Has a claim been filed with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," send initial report of illness or injury and award notice.	Date employee is expected/did return to work _____  Full time? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**E. Information About Salary**

Employee's weekly/hourly rate of pay \$ \_\_\_\_\_

Is employee receiving Salary Continuance or Sick Leave?  Yes  No

Weekly Amount \$ \_\_\_\_\_ Date Payments Start \_\_\_\_\_ Date Payments Will End \_\_\_\_\_

Will/Is Employee receive(ing) Workers' Compensation Payments?  Yes  No

Weekly Amount \$ \_\_\_\_\_ Date Payments Start \_\_\_\_\_ Date Payments Will End \_\_\_\_\_

**F. Information About the Physical Aspects of the Employee's Job**

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

- Not Applicable** means the person does not perform this activity.
- Occasionally** means the person does the activity up to 33% of the time.
- Frequently** means the person does the activity 34% to 66% of the time.
- Continuously** means the person does the activity 67% to 100% of the time.

Activity	FREQUENCY OF OCCURRENCE			
	N/A	Occasionally	Frequently	Continuously
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<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"/>
<input type="checkbox"/> Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crouching	<input type="checkbox"/>	<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"/>
<input type="checkbox"/> Reaching/Working Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<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"/>

Activity	Description	Frequency	Weight	
<input type="checkbox"/> Pushing	_____	_____	_____	lbs.
<input type="checkbox"/> Pulling	_____	_____	_____	lbs.
<input type="checkbox"/> Lifting	_____	_____	_____	lbs.
<input type="checkbox"/> Carrying	_____	_____	_____	lbs.

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

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks.

\_\_\_\_\_ %  
 \_\_\_\_\_ %  
 \_\_\_\_\_ %

**G. 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.

**H. Signature**

_____ Name (Please print or type)	_____ Title
_____ Signature	_____ Date
( ) _____ Area Code Telephone Number	( ) _____ Area Code Fax Number

APPLICATION FOR GROUP DISABILITY INCOME BENEFITS  
HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Section II  
Employee's Statement

To be Completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS — FAILURE TO DO SO MAY DELAY YOUR CLAIM)

**A. Information About You**

Last name	First	Middle Initial	Social Security Number		
Address (Street)			City	State/Province	ZIP
Telephone Number ( ) Area Code	Date of Birth (Month, Day, Year)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	

Your employer (include division, if applicable)

**B. For an injury, answer the following questions:**

When, (i.e., date/time), where and how did the injury occur?

**C. For illness, injury or pregnancy, answer the following questions:**

Date you were first treated by a physician?  (Month, Day, Year)	Name of Physician _____ Address of Physician _____ Telephone Number ( ) _____
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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?

Are you receiving or eligible for  Workers' Compensation  State Disability  No Fault Disability  Other

If "Yes," show policy number \_\_\_\_\_ and name and address of insurer \_\_\_\_\_

Weekly Amount \$ \_\_\_\_\_ Date Payments Start \_\_\_\_\_ Date Payments Will End \_\_\_\_\_

Is your condition related to your occupation?  Yes  No If "Yes," explain.

Have you filed, or do you intend to file, a Workers' Compensation claim?  Yes  No If "No," explain.

**D. Information About the Disability**

Last day you worked before the disability  (Month, Day, Year)	Did you work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No" explain.	Date you were first unable to work  (Month, Day, Year)
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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 Part time (date) \_\_\_\_\_ Full time (date) \_\_\_\_\_

No

**E. Information about Tax Withholding**

Federal law requires us to withhold federal income tax from your check **if you request us to do so**. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is \$20.00 per week): \$ \_\_\_\_\_ .00.

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

F. Signature

With the exception of any source(s) of income reported above in Section D of this form, I certify by my signature that I have not and am not eligible to receive any source of income, except for my Hartford Disability Income. 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 benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company 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 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 a 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 an insurance policy is subject to criminal and civil penalties.

**For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading 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.

The statements contained in this application for Long Term Disability Income Benefits are true and complete to the best of my knowledge and belief.

X \_\_\_\_\_ X \_\_\_\_\_  
SIGNATURE OF THE EMPLOYEE DATE

PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR ANOTHER DOCUMENT THAT VERIFIES YOUR DATE OF BIRTH.

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, Medical Information Bureau, Inc., Health Claims Index, 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 Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and any affiliate of one or more of these three companies, known collectively as The Hartford; or (ii) The Hartford's 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 or 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 further authorize The Hartford or its reinsurers to request a report from the Medical Information Bureau (MIB), which is an association of life insurance companies that operates the Health Claim Index (HCI) on behalf of subscriber insurers. I understand that The Hartford may also send a brief report to HCI. An HCI report includes the dates of claims filed for or by me, claim date of loss and the names of companies to which claims were submitted, but does not contain medical information. Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my HCI file. If I question the accuracy of information in the file, I may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

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 The Hartford to any person or organization EXCEPT to reinsuring companies or their representatives. The Index System, Medical Information Bureau, Health Claim Index, 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 a 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

Attending Physician's Statement

HISTORY

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_ D.O.B. \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

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 \_\_\_\_\_ LMP Date \_\_\_\_\_

Is condition due to an illness or an injury that is work related?  Yes  No

DIAGNOSIS

Diagnosis (including any complications) \_\_\_\_\_

ICD9 Codes: \_\_\_\_\_

Subjective Symptoms: \_\_\_\_\_

Physical Findings (list all results, or enclose test):

Test: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Test: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Blood Pressure (Systolic) \_\_\_\_\_ (Diastolic) \_\_\_\_\_ (Date) \_\_\_\_\_

Remarks: \_\_\_\_\_

TREATMENT

Date of onset of this condition: \_\_\_\_\_ List all dates of treatment for this condition since patient ceased work \_\_\_\_\_ Date of next office visit \_\_\_\_\_

Has patient been referred to any other physician?  Yes  No Date(s) \_\_\_\_\_

If "Yes," name and address \_\_\_\_\_ Speciality: \_\_\_\_\_

Nature of treatment for this condition (including surgery/medications) \_\_\_\_\_

Was patient hospitalized for this condition?  Yes  No If "Yes," date(s) admitted: \_\_\_\_\_ date(s) discharged: \_\_\_\_\_

Name and address of hospital(s): \_\_\_\_\_

Was surgery performed?  Yes  No If "Yes," Date \_\_\_\_\_ Procedure: \_\_\_\_\_ CPT Code: \_\_\_\_\_

Progress (Please check one):  Recovered  Improved  Unchanged  Retrogressed

IMPAIRMENT

What are the patient's current physical limitations and restrictions?

- No limitation of functional capacity; capable of heavy work, no restrictions. (Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)
 Medium manual activity (Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)
 Slight limitation of functional capacity; capable of light work (Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.)
 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)
 Severe limitation of functional capacity; incapable of minimal (sedentary) activity

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, indicate the date limitations have lasted, or will last through: \_\_\_\_\_ (Month, Day, Year)

Attending Physician's Name: \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_ FAX # (\_\_\_\_\_) \_\_\_\_\_ Area Code Area Code

SS# or E.I.N.#: \_\_\_\_\_ Degree: \_\_\_\_\_ Specialty: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_