Fax completed application to:
CBIA Insurance Operations
350 Church Street
Hartford, CT 06103
Fax Number: (860) 278-0883

Clear Form

THE HARTFORD

APPLICATION FOR SHORT 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
CBIA Service Corp

Address (Street, City, State, Zip)

Name Of CBIA Participating Employer

Group Policy Number		
678223 CBIA Group		

B. Information About the Employee

Date employee was hired

Date employee became insured under this plan

Is the employee a union member? ☐ Yes ☐ No
If Yes, name of union and local number:

What was the employee's regularly scheduled work week?

_____ Hours per Week _____ 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

What percent of this employee's STD benefit is taxable? _____%.
What percentage, if any, do you contribute towards the cost of the STD premium? _____%
Does the employee contribute towards the cost of the STD premium? ☐ Yes ☐ No. If "Yes," at what percent? _____%.
Is it on a ☐ Pre or ☐ Post-tax basis?
What percent of this employee's LTD benefits is taxable? _____%
Does the employee contribute towards the cost of the LTD premium? ☐ Yes ☐ No. If "Yes," at what percent? _____%
Is it on a ☐ Pre or ☐ Post-tax basis?

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? ☐ Yes ☐ No
If "No," how many hours were worked? _____

Why did employee stop working?

Is the employee's condition work related? ☐ Yes ☐ No

Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No
If "Yes," send initial report of illness or injury or award notice.

Date employee is expected to return to work? _____
Full time? ☐ Yes ☐ No

E. Information About Salary

Employee's weekly/hourly rate of pay: $_____

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

Weekly Amount: $_____ Date Payments Start: _____ Date Payments Will End: _____

Is employee receiving Salary Continuance? ☐ Yes ☐ No or Sick Leave? ☐ ☐

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.
Select either majority of workday or sporadically.

Activity	Majority of workday (with standard breaks)		Sporadically throughout day	If sporadically circle time for each section below: Hours at one time	Total hours/8 hour
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

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

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

Lift/Carry/Push/Pull: Task Description (Describe object moved and any mechanical assistance in the last column)					
Lifting		lbs.	lbs.	lbs.	
Carrying		lbs.	lbs.	lbs.	
Pushing/Pulling		lbs.	lbs.	lbs.	

Upper Extremity Activity (not load bearing)	**Specify right (R) or left (L) if not bilateral)**				**Describe task performed**
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

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

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THE HARTFORD

Employee's Section

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:	Gender: ☐ Male ☐ Female	Date of Birth:	Social Security Number:

Address: (Street, City, State & Zip)

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

E-Mail Address:

E-Mail is used to provide The Hartford At Work registration instructions and important status updates.

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

Name of Healthcare Provider:

Date you were first treated by a Healthcare Provider: (MM/DD/YYY)

Address of Healthcare Provider: (Street, City, State & Zip)

Telephone Number: ( )

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 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 If "No," explain:

D. Information About the Disability

Last day you worked before the disability:

Did you work a full day? ☐ Yes ☐ No If "No," explain:

Your Employer: (include division, if applicable)

If you have not returned to work, do you expect to? ☐ Yes ☐ No Date you were first unable to work:

Since that date, have you done any work? ☐ Yes ☐ No ☐ Part time ☐ Full time
If "Yes," please indicate dates worked, name of employer and amount earned:

Name of employer and amount earned.

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

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

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

For residents of Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

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

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

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

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

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

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The statements contained in this form are true and complete to the best of my knowledge and belief.

_____ _____

Signature Date

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.