

Please 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



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.)				
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? <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? _____	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: () Fax: ()	Specialty:
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: () 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.

G. 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 \$88.00 per month): \$ _____ .00. **IMPORTANT:** If you pay the entire cost of the LTD premium, but on a Post-tax basis per Section I, Part D of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed state Tax Withholding Certificate from you. Please contact your employer or state Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed federal Form W-4, Employee's Withholding Allowance Certificate, from you. You may go to www.irs.gov to obtain the proper withholding form.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company. Home Office is Hartford, CT. 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.

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 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.

Please fax the completed form to:

Fax Number: 833-357-5153

The Hartford

P.O.Box 14869

Lexington, KY 40512-4869

Email: GBIInformationUpload@thehartford.com

ATTENDING PHYSICIAN'S STATEMENT



To be completed by the Employee

Patient Name: _____ Date of Birth: _____ Insured ID Number: _____

Patient Address: (Street, City, State & Zip Code) _____

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Patient's condition is the result of: Sickness Injury Pregnancy

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

Is condition due to illness or an injury that is related to: Work Activity Motor Vehicle Accident

Medical Conditions Impacting Activity

Primary condition: _____ ICD-9 Code: _____
ICD-10 Code: _____

Secondary condition(s): _____ ICD-9 Code: _____
ICD-10 Code(s): _____

Subjective symptoms: _____

Objective Physical Findings (Please include office notes for date(s): _____ to _____

Pertinent Test Results (list all results or attach test results):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Condition(s) Specific Medications, Dosage and Frequency:

Treatments

Date your patient reported stopping work: _____ Date of disability: _____ Expected Return to Work Date: _____

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

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

How often has patient been seen/treated for this condition? _____ Date of next office visit: _____

Current Treatment Plan: _____

Has surgery been performed? Yes No Is surgery planned? Yes No If "Yes," Date: _____

Procedure: _____ CPT Code: _____

Was patient hospitalized for this condition? Yes No If "Yes," Date(s) admitted: _____ Date(s) Discharged: _____

Name of Hospital: _____ Telephone Number of Hospital: () _____

Has patient been referred to any other physician? Yes No If "Yes," Date(s) of Referral: _____

Other Physician Name: _____ Phone Number: () _____ Specialty: _____

Other Physician Name _____ Phone Number: () _____ Specialty: _____

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company. Home Office is Hartford, CT. 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.

Patient Name:

Date of Birth:

Insured ID Number:

Complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your medical findings and opinion, address the full range of restrictions/limitations at the time patient stopped working, reduced their work schedule or initially visited your office for this condition, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: _____

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks	or	Intermittently with standard breaks	If intermittent circle time for each section below															
				Hours at one time								Total hours/8 hours							
Sit	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Stand	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Walk	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel/crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift - Indicate weight in pounds		_____ lbs.	_____ lbs.	_____ lbs.	
Other Restrictions (if any) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hand Dominance: Right Left

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

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"/>	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: _____

Current Status (Please check one): Recovered Improved Unchanged Retrogressed

Additional Comments (If Necessary): _____

Does the patient have a psychiatric / cognitive impairment? Yes No If "Yes," please describe the extent of the impairment and its etiology: _____

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? Yes No

Provider's Name: (please print or type)

EIN Number:

License Number:

Telephone Number: ()

Fax Number: ()

Degree:

Specialty:

Street Address (Street, City, State & Zip Code):

Office Contact and Telephone Number:

Provider's Signature: _____

Date signed: _____

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 drug abuse, and mental health; 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, 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 (all entities and individuals listed in this paragraph including The Hartford defined as "Benefits Manager(s)"). I understand that My Information disclosed to Benefits Managers and re disclosed could include HIV/AIDS, other communicable diseases and mental health records.

I understand that My Information disclosed to Benefits Managers pertaining to certain alcohol or drug abuse treatment is protected by federal (42 CFR Part 2) and state confidentiality rules and statutes, which prohibit any further disclosure of this information without my express written consent, or as otherwise permitted by such rules and statutes. I understand that a general authorization for the release of medical or other information is NOT sufficient for release of certain types of alcohol or drug abuse treatment records.

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(Continue to next page)

Therefore:

If any of my records contain information about alcohol or drug abuse, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the benefits program. I understand that the federal rules restrict any use of the Information to criminally investigate or prosecute any drug or alcohol abuse patient.

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 revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, 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.

If I change my mind about this Authorization before that time is up, I can tell my Records Holders and The Hartford in writing that I do not want them to share any more information with other parties. If I revoke my Authorization by telling them in writing to stop sharing information with other parties, it will not change any actions they took before I revoked my permission. If I do not sign this Authorization, it will not affect how my health care providers treat me. However, if I do not sign, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in 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.

Electronic Funds Transfer (EFT) Request Form



Instructions

1. Read the Terms and Conditions listed below.

2. Enter your name, address, home telephone number and Employee ID.

3. Complete the bank and account information for your Electronic Funds Transfer request.

4. You and all other parties to the account specified must sign this form.

5. Return the completed form to The Hartford Claims Office.

Note: Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the EFT Program.

Name: _____

Address: _____

Telephone Number: () - _____

Employee ID: _____

Name of Bank: _____

Bank Address: _____

Bank Telephone Number: () - _____

Type of Account (select one):

Checking:

Saving:

Account Number: _____ Account Number: _____

Bank Routing Number: _____

Attach a voided blank personal check.

Indicate any other names on the account selected:

AUTHORIZATION

I / We authorize (_____) and affiliated companies (herein after called The Hartford), to initiate credit entries (and to initiate, if necessary, debit entries and adjustments for credit entries made in error) to my (our) account indicated above and the Depository named above, hereinafter called Depository, to credit and/or debit the same to such account. I (we) acknowledge that the origination of A C H transactions to my (our) account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until The Hartford has received written notice from me (us) of its termination in such time and in such manner as to afford The Hartford and Depository a reasonable opportunity to act on it.

Signature(s): _____

Date: _____

TERMS AND CONDITIONS

The Hartford will not be responsible for any banking fees charged for direct deposit or electronic funds transfer.

I understand that this agreement may be terminated by me upon written notice to The Hartford.

The cancellation will be processed for the time period following receipt of the notice.

I understand that a change in the title of this account which alters the interest of any party terminates this authorization and that a new authorization must then be submitted to continue direct deposit/EFT.

I understand that it is my responsibility to inform The Hartford of any address changes immediately.

I further understand that any benefit payment forwarded to the financial institution covering a period of time after my death will be refunded to The Hartford. I agree that the financial institution shall have the right of offset for such a refund.

I authorize the financial institution specified in this authorization to provide The Hartford with my home address and the names of any joint account holders for the account specified herein.

I understand that I am responsible for verifying the accuracy of my account data and for promptly notifying The Hartford of any errors or changes including termination of my EFT request.

SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

As a party to this account, I understand that I am personally liable, both individually and as a member of the group of parties to this account, for the full amount of all benefit payments covering any period after the death of the disability benefit recipient. This is a liability to The Hartford. If I am entitled to any benefit as the beneficiary of the disability benefit recipient, the amount of my liability may be deducted from the amount payable to me. I agree that the financial institution shall have the right of offset for such a refund, and I authorize the financial institution to provide The Hartford with my home address.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to The Hartford or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so. The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately notify The Hartford if the authorization is cancelled by the financial institution. The financial institution can not cancel the authorization by advice to The Hartford.



Signature:

Date:

I certify that I have read and understand the Terms and Conditions of this EFT Agreement, including the SPECIAL NOTICE TO OTHER PARTIES TO THIS ACCOUNT.

Signature(s) of Other Persons on Account:

Date

Date:

Fax or mail the completed application to:
The Hartford
 P.O. Box 14301
 Lexington, KY 40512-4301
 Fax Number: (866) 411-5613



EMPLOYER SECTION
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: Wachusett Regional School District		Group Policy Number: GLT 888163
Address: (Street, City, State, Zip) 1745 Main Street, Jefferson MA 01522		Telephone Number: (508) 829-1670
Name and address of division where employee works: (if different from above)		Fax Number: (508) 829-1680
		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		Is the employee a union member? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did LTD insurance continue while on Family Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, name of union and local number.
Date Leave of Absence started under Family Leave Act: _____		

C. Information for Group Life Premium Waiver 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: _____
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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 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
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		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)	<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 _____

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