



Personal Health Application

Applicants must complete this form if they have requested insurance coverage for themselves or any of their family members and are required to provide evidence of insurability.

Instructions

Employer's Responsibility:

1. Fill out the Employer Section completely. Please note an incomplete form will result in a delay in processing the applicant(s) request for insurance. Refer to your Policy and employee records. These records are your property and are not on file with The Hartford's Group Medical Underwriting Department.
2. In Section #1, "Who Requires an Application," indicate with a check mark why evidence of insurability is required – for employee and/or dependent(s). See definitions in #3 below. Consult your Policy for all requirements, limitations, and exceptions.
3. In Section #2, "Coverage Summary," complete all coverage amounts for each Applicant. **Basic Life coverage amounts are important and must be included for all Applicants requesting additional Life coverage.** Consult your employee records to determine current coverage amounts. Please note that The Hartford does not have access to employee records for amounts of coverage already in force. The term "Supplemental" refers to any additional amount of coverage provided above and beyond the Basic amount provided by your plan. The term "Voluntary" refers to any coverage where the applicant(s) is required to pay the entire cost of the plan. **Definitions of coverage requests:**
 - **Over Guaranteed Issue (GI) Limit:** Election of coverage exceeding the guaranteed issue amount (according to your contract) for which evidence of insurability is required.
 - **New Hire:** Newly hired employee electing coverage for the first time within the eligibility period, usually the first 31 days from date of hire.
 - **Opting up to Higher Level of Coverage:** Election of additional increment(s) of coverage with insurance currently in force.
 - **Late Entrant:** Employee who did not enroll during one of the following eligibility periods: initial eligibility date of hire or date of family status change, or during an annual enrollment and does not currently have coverage in force. (*Note: Applicant is responsible for payment of any additional information required for completion of the underwriting process e.g. exams, medical records, etc*).
 - **Change in Family Status:** Election of coverage usually made within 31 days of a qualified change in family status.
 - **Earnings Increase (for Employees ONLY):** Employee applying for additional coverage due to an increase in the amount of annual earnings.
4. After completing the Employer Section on page 2, forward the entire form to the employee.
5. No premiums may be deducted on additional amounts requiring evidence of insurability until a final decision regarding coverage is received from The Hartford's Group Medical Underwriting Department.

Employee's Responsibility:

Upon Completion

Send both the Employer and Employee Sections of this form to:

The Hartford
Group Medical Underwriting
PO Box 2999
Hartford, CT 06104-2999

1. Make sure your Employer has already completed the Employer Section of this form in full.
2. Enter the name(s) of the Applicant(s) under "Applicants Required to Provide Evidence of Insurability." The Employer Section clarifies which Applicants need to provide evidence of insurability and should be listed on this application. A box has been marked for each person who is required to fill out the application in the section entitled "Who Requires an Application" on the "Employer" page.
3. Answer all questions completely and accurately. Even details like height and weight are very important and must be accurate. **Leaving information blank can result in delays or may result in your file being closed.**
4. An Applicant who has not enrolled during their eligibility period or annual enrollment and does not have coverage in force (shown in the Employer Section #1) will be responsible to pay for the cost of physical exams, medical records, or medical tests if they are required during the underwriting process.
5. YOU, THE EMPLOYEE, MUST SIGN THIS FORM (even if you are not applying for coverage). Use your full legal signature and enter the date signed. Your spouse must sign this form ONLY if using this form to apply for coverage. He or she must use a full legal signature and enter the date signed.
6. **BOTH THE EMPLOYER AND EMPLOYEE SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY THE HARTFORD WITHIN 30 DAYS OF THE SIGNATURE DATE.**

Personal Health Application

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company.

Employer Name:			
Division (If Applicable):		Policy Number:	
Street Address:			
City:		State:	Zip:
Benefits Contact First Name:	Benefits Contact Last Name:	Benefits Contact Phone:	
Employee First Name:		MI:	Last Name:
Date of Hire:	Family Status Change Date:	Employee Social Security Number:	
Base Annual Earnings (BAE): \$	Earnings Increase Amount: \$	Effective Date of Increase:	

1. Who requires an Application: Refer to "Definitions of Coverage" in #3 on the Instructions page. Select a box for each Applicant required to provide evidence of insurability.

Employee (EE)	<input type="checkbox"/> Over Guaranteed Issue Limit	<input type="checkbox"/> Opting up to Higher Level of Coverage	<input type="checkbox"/> Late Entrant	<input type="checkbox"/> Change in Family Status	<input type="checkbox"/> Earnings Increase <i>(Employee Only)</i>
	<input type="checkbox"/> New Hire				
Spouse (SP)	<input type="checkbox"/> Over Guaranteed Issue Limit	<input type="checkbox"/> Opting up to Higher Level of Coverage	<input type="checkbox"/> Late Entrant	<input type="checkbox"/> Change in Family Status <i>(e.g. marriage)</i>	
Child (CH)	<input type="checkbox"/> Over Guaranteed Issue Limit	<input type="checkbox"/> Opting up to Higher Level of Coverage	<input type="checkbox"/> Late Entrant	<input type="checkbox"/> Change in Family Status <i>(e.g. newborn)</i>	

2. Coverage Summary: Complete all three columns for each Applicant. **Life Coverages:** Be sure to include any Basic Life coverage as a dollar amount value for all Applicants requesting Supplemental/Voluntary Life coverage. For most policies, Life coverage can be calculated as 1,2,3 etc. times salary or in dollar amount increments for increment plans.

Applicants Coverage	Class:	Current Coverage Amount In Force (i.e. GI coverage if eligible or any existing coverage prior to this enrollment)	Additional Amount Applied For (Amount to be medically underwritten)	Total Coverage (Combination of current coverage and additional amount requested)
Employee: Basic Life:	Class:	\$	\$	\$
Supp. Or Vol. Life:	Class:	\$ <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x x Other multiple	\$ <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x x Other multiple	\$ <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x x Other multiple
Spouse: Basic Life:	Class:	\$	\$	\$
Supp. Or Vol. Life:	Class:	\$	\$	\$
Child: Basic Life:	Class:	\$	\$	\$
Supp. Or Vol. Life:	Class:	\$	\$	\$
(Employee Only):	Class:			
Long Term Disability:		monthly	monthly	monthly
	Class:			
Short Term Disability:		Weekly	Weekly	Weekly

Employee First Name:		MI:	Last Name:	
Street Address (include Apt., Suite or Floor):				
City:			Day Time Phone:	
State:	Zip:	Social Security Number:	Evening Phone:	
Email Address:				
Employer:				
Spouse Day Time Phone:		Spouse Evening Phone:		

1. Applicants Required to Provide Evidence of Insurability (This is critical information and if left blank will cause a delay in processing your insurance request). List the names of Applicants identified in Employer Section I.

Employee (EE)	Spouse (SP)	Child (CH)
<input type="checkbox"/> I am required to provide evidence	First Name:	First Name:
If checked above, please complete the following:		
Occupation:	Last Name:	Last Name:
Date of Birth:	Date of Birth:	Date of Birth:
Height: ft. in. (required)	Height: ft. in. (required)	Height: ft. in. (required)
Weight: lbs. (required)	Weight: lbs. (required)	Weight: lbs. (required)
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female (required)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female (required)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female (required)

2. Health Questions (Questions 1-24 are to be answered by all Applicants listed above. If additional space is required, please attach a separate sheet. Sign and date each sheet.) If you are a resident of one of the following states: Florida, Indiana, Maine, Minnesota, New York, North Carolina, Vermont, or Wisconsin, then please go to the State Variable Question section on page 6 of the application and answer or review the appropriate question for your state. After you have read that information, proceed with completing this section.

For questions 1-6, during the past 10 years, have any of the Applicants: (Residents of: Indiana, Kansas, Maryland, and Minnesota, please provide medical history during the past 5 years.)

	EE		SP		CH	
	Yes	No	Yes	No	Yes	No
1. Had any surgery or been told to have surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Been in a hospital or other institution for diagnosis or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Had any injuries from a car accident or filed a Workers' Compensation Claim?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Been declined for any life or disability insurance coverage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Consulted or been examined by any healthcare provider for anything <u>other than</u> a routine physical with normal findings or acute illness such as cold, flu, or sore throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Had any lab tests, X-ray, electrocardiogram or other diagnostic testing <u>other than</u> those requested as part of a routine physical with normal findings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*****For each "YES" answer, identify the question number, applicant name and provide details requested*****

Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address:		
Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address:		

For questions 7-24, during the past 10 years, have any of the Applicants at any time been treated or told they have a problem with any of the following: (Residents of: Indiana and Maryland, please provide medical history during the past 5 years.)

	EE		SP		CH	
	Yes	No	Yes	No	Yes	No
7. Heart condition, chest pain, high blood pressure, elevated cholesterol, heart murmur, abnormal pulse, stroke, or blood, circulatory or vascular system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Cancer, tumors, leukemia, moles, melanoma, or basal cell carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Diabetes, thyroid, liver, hepatitis, glands or spleen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Asthma, bronchitis, pneumonia, respiratory problems, or sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Ulcers, stomach, colitis, rectum, intestines, gallbladder, or upper or lower digestive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Arthritis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Kidneys, bladder, or urinary tract?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Genital or reproductive organ problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For each "YES" answer, identify the question number, Applicant name and provide details requested

Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address:		
Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address:		
Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address:		
Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address:		
Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address:		

EMPLOYEE: FIRST NAME _____ LAST NAME : _____

	EE		SP		CH	
	Yes	No	Yes	No	Yes	No
15. Drug or alcohol abuse, or used alcohol or nicotine on a regular basis? Indicate amount used daily:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Psychiatric, mental or nervous disorders, including depression and anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Back, neck, spine, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Immune system, anemia or other blood conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Brain or nervous system problems or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), or any other immune deficiency disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Are you currently pregnant? If yes, what was your pre-pregnancy weight? lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Are you currently taking medication for any condition or disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Any symptoms, injury, birth defect, congenital defect, disease or disorder not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For each "YES" answer, identify the question number, Applicant name and provide details requested

Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address :		
Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address :		
Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address :		
Question no.:	Applicant name:	Medical condition:
Date of diagnosis:	Date treatment started:	Date treatment ended:
Date of last symptom:	Current status of condition:	Medications/Treatment:
Any limitations or residuals: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" list any limitations or residuals:		
Physician's name and complete address :		

Employee Primary Care Physician Name & Address:

Spouse Primary Care Physician Name & Address:

State Variable Questions

For residents of Florida, Indiana, Maine, Minnesota, New York, North Carolina, Wisconsin and Vermont review or answer the question listed below instead of the corresponding question listed in the Health Questions section. Any "Yes" responses can be explained in the detail box provided in the Health Questions section.

Information to be Reviewed

Maine residents: Please review this prior to answering any of the health questions.

You are not required to disclose whether you have been tested for HIV, if you have not developed symptoms of the disease AIDS or ARC, in your answer to any of the following questions.

Minnesota residents: Please review this prior to answering any of the health questions.

YOU NEED NOT DISCLOSE AN HIV (AIDS VIRUS) TEST WHICH WAS ADMINISTERED: (1) TO A CRIMINAL OFFENDER OR CRIMINAL VICTIM AS A RESULT OF A CRIME THAT WAS REPORTED TO THE POLICE; (2) TO A PATIENT WHO RECEIVED THE SERVICES OF EMERGENCY MEDICAL SERVICES PERSONNEL AT A HOSPITAL OR MEDICAL CARE FACILITY; (3) TO EMERGENCY MEDICAL PERSONNEL WHO WERE TESTED AS A RESULT OF PERFORMING EMERGENCY MEDICAL SERVICES.

Questions to be Answered

Florida residents: Do not answer Question 21 in the Health Questions section. Answer the following question below.

Question 21: Has anyone proposed for coverage ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or had unexplained weight loss or enlarged lymph nodes?

Employee: Yes No Spouse: Yes No Child: Yes No

Indiana residents: Do not answer Question 24 in the Health Questions section. Answer the following question below.

Question 24: Please list injury, birth defect, or congenital defect not mentioned above.

Employee: Yes No Spouse: Yes No Child: Yes No

Minnesota Residents: Do not answer Question 24 in the Health Questions section. Answer the following question below.

Question 24: Please list any symptom, injury, birth defect, congenital defect, disease, or other disorder not mentioned above that has been diagnosed or treated by a medical practitioner.

Employee: Yes No Spouse: Yes No Child: Yes No

New York Residents: Do not answer Question 21 in the Health Questions section. Answer the following question below.

Question 21: Have you been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), or any other immune deficiency disorder (excluding HIV)?

Employee: Yes No Spouse: Yes No Child: Yes No

North Carolina residents: Do not answer Question 21 in the Health Questions section. Answer the following question below.

Question 21: Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? "AIDS Related Complex (ARC)" is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

Employee: Yes No Spouse: Yes No Child: Yes No

Vermont residents: Do not answer Question 21 in the Health Questions section. Answer the following question below.

Question 21: Has anyone been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician?

Employee: Yes No Spouse: Yes No Child: Yes No

Wisconsin residents: Do not answer Question 6 in the Health Questions section. Answer the following question below.

Question 6: Had any lab tests, x-ray, electrocardiogram, or other diagnostic testing other than HIV testing or those requested as part of routine physical with normal findings?

Employee: Yes No Spouse: Yes No Child: Yes No

CERTIFICATION

Residents of All States: I hereby certify (“**represent**” for **Kansas residents**) that all statements and answers contained herein, are full, complete, and true to the best of my knowledge and belief.

Residents of All States Except New York: I also understand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the coverage, within the contestable period if such misrepresentation materially affects acceptance of the risk. This information may be used by The Hartford for plan administration purposes to decide if the person(s) is/are eligible for coverage.

I understand that coverage will not become effective until The Hartford grants it’s underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

I agree that this document and all its contents shall form a part of my request for group benefits.

AUTHORIZATION

New York Residents: I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford. I authorize The Hartford to give information about me to: its reinsurer(s); the Medical Information Bureau, Inc.; any other insurance company to whom I may apply for Life or Health Insurance; or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application; or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires 24 months from the date of this application. I understand that a photocopy of this form is as valid as the original; and that I have a right to receive a copy of this form upon request

Residents of All States Except New York: I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford. I authorize The Hartford to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I may apply for Life or Health Insurance, or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application; or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires 24 months from the effective date of my coverage or, if no coverage has been issued one (1) year from the date of this application. I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request.

Additional Language for Maine Residents: This authorization excludes disclosure of the result of a test for HIV if the applicant has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS or ARC. I understand that my failure to sign this authorization may impair the ability of The Hartford to process this application or evaluate claims and may be a basis for denying this application or a claim for benefits.

Additional Language for Minnesota Residents: This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or criminal victim as a result of a crime that was reported to the police; (2) to a patient who received the services of Emergency Medical Services personnel at a hospital or medical care facility; or (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term “Emergency Medical Personnel” includes individuals employed to provide pre-hospital emergency services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and would qualify for immunity under the Good Samaritan Law.

EMPLOYEE: FIRST NAME _____ LAST NAME : _____

FRAUD NOTICE

Residents of All States Except California, Pennsylvania and New York: 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.

California Residents: 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.

Pennsylvania Residents: 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 subjects a person to criminal and civil penalties.

New York Residents: 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.

Notice: To the best of their knowledge, an Applicant is required to notify The Hartford in writing of any changes in any applicant's medical condition between the date the Applicant signs this form and the date the coverage is approved.

_____ EMPLOYEE'S SIGNATURE or Legal Representative/ Relationship to Employee (required)	_____ / / DATE SIGNED	_____ SPOUSE'S SIGNATURE or Legal Representative/ Relationship to Spouse (required only if applying for coverage)	_____ / / DATE SIGNED
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Please return the completed Employer and Employee sections to:
The Hartford, Medical Underwriting
P.O. Box 2999
Hartford, CT 06104-2999

After submitting this application, you can check your status on line at **www.TheHartfordAtWork.com**.

If you have any questions or concerns, please call The Hartford Customer Service Department toll-free at 1-800-331-7234, Monday through Friday, 8:00 a.m. to 6:00 p.m., Eastern Time, or email us at medical.uw@hartfordlife.com.

EMPLOYEE: FIRST NAME _____ LAST NAME : _____

**Authorization to Disclose Protected Health Information
To Be Used To Determine Eligibility for Group Life and/or Disability Income Coverage
(Group Life and Disability Income are not subject to the requirements of HIPAA)**

I have applied for insurance under a Group Life and/or Disability Policy issued by The Hartford. To assess whether I am eligible for this insurance, these companies may require that I authorize disclosure of a copy of my health information. This authorization is intended to comply with the requirements under §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), effective April 14, 2003.

I **authorize** any: health plan, physician, medical or health practitioner, counselor, therapist, hospital, clinic, other medical or medically-related facility, or other health care provider who has provided treatment, payment, or services to me or on my behalf within the last 10 years (**Residents of Indiana** authorize within the last 5 years); insurance company; or reinsurance company, with which I have had coverage, and the Medical Information Bureau, Inc. (MIB), (collectively, “Releasers”); to disclose to The Hartford, Health Information about me. The Hartford may disclose the Health Information: to their agents; to their employees; and to their representatives (collectively “The Hartford”); my entire Health Information. Health Information means the entire medical file. This includes, but is not limited to: x-rays; photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes, that relate to: 1) Pre-existing or current illnesses, sicknesses, disease, disabilities, disorders, accidents, injuries, or any other health conditions, 2) Confinements in hospitals, medical facilities, or medical clinics, 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners, 4) Drug use, alcohol use, or mental health information protected by Federal Law, 5)* Counseling or therapy. Health information also means information on the diagnosis and treatment of mental illness. But, it excludes psychotherapy notes as defined by HIPAA. I understand that the MIB will only disclose health information to The Hartford. The Hartford will use this information to underwrite my request for coverage; make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to any coverage I have applied for with The Hartford.

***Residents of West Virginia**, 5) reads as follows: Counseling or therapy, except that no adverse underwriting decision shall be made because I have demonstrated AIDS-related concerns or have sought AIDS-related counseling (this does not apply to my seeking treatment and/or diagnosis for Acquired Immune Deficiency Syndrome).

By signing this Authorization, I acknowledge and agree:

- That any agreements I have made to restrict disclosure of my health information do not apply to this Authorization;
- That I am authorizing the Releasers to release and disclose my entire medical file, as described above, without restriction.

By signing this Authorization, I acknowledge that I understand the following:

- That health information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the Releasers’ knowledge. Note that The Hartford only will use this information to underwrite your request for coverage; make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to coverage you have applied for with The Hartford.
- That if 1) I refuse to sign this Authorization to release my entire medical file; or 2) if this Authorization is altered by me in any way, The Hartford may not be able to process my application for coverage.
- That, if 1) The Hartford denies my request for coverage; and 2) this denial is based, in whole or in part, on health information obtained in connection with this Authorization; The Hartford will not release this information to me unless otherwise authorized by the Releasers, including my physician or other medical professionals that disclosed such information to The Hartford unless required by law.
- That, if necessary, The Hartford will send this Authorization to Releasers authorized to release health information about me.
- That The Hartford will also provide me with written notice of Releasers to which The Hartford sends my Authorization.
- That I have a right, at any time, to revoke this Authorization. To do so, I must send a written request directly to such Releasers. My revocation will not be effective: to the extent that action has been taken in reliance upon this authorization; or, The Hartford otherwise has the right: to contest the policy; or a claim under the policy.

Residents of Virginia, review this additional text: Authorization signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits remain valid no longer than 30 months from the date the authorization is signed. Authorizations signed for the purpose of collecting information in connection with a claim for accident and sickness benefits under an insurance policy remain valid for the entire term of the coverage of the policy. Authorizations signed for the purpose of collecting information in connection with a claim for any other benefits under an insurance policy remain valid for the duration of the claim.

- That this Authorization will expire 24 months from the effective date of my coverage or if no coverage has been issued, 24 months from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original.
- That I am entitled to a signed copy of this Authorization.

EMPLOYEE’S SIGNATURE
or Legal Representative/
Relationship to Employee
(required)

DATE SIGNED

SPOUSE’S SIGNATURE
or Legal Representative/
Relationship to Spouse
(required only if applying for coverage)

DATE SIGNED