



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

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

Section I Employer's Statement - to be completed by the employer's authorized representative. Be sure to provide any necessary attachments (see Section K).

I C. Information for Group Life Premium Waiver Benefits - to be completed by the employer's authorized representative if the employer also has a Group Life Insurance policy with The Hartford that includes a Premium Waiver benefit. Be sure to provide any necessary attachments (see Section K)

Section II Employee's Statement - to be completed by the employee who is applying for Long Term Disability benefits. Please attach a copy of the employee's driver's license.

Section III Authorization to Obtain Information - to be signed by the employee.

Section IV Attending Physician's Statement - to be completed by the physician who is treating the employee.

Group Benefit Associates
1701 E. Lake Avenue, Suite 400
Glenview, IL 60025

Telephone: 800-450-1271
Fax: 773-427-6875
Email: CustomerService@groupba.com

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

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



APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

Section I - 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)		

A. Information About the Employer

Company's Name: IBEW Local 9, c/o Group Benefit Associates	Group Policy Number:	
Address: (Street, City, State, Zip) 3963 W. Belmont Ave., Suite 6, Chicago, IL 60618	Telephone Number: (800) 450-1271	Fax Number: (773) 427-6875
Name and address of division where employee works: (if different from above)	Class:	Location:

B. Information About the Employee

Date employee was hired:	Date employee became insured under this plan:	What was the employee's regularly scheduled work week? _____ hours per week.
Was the employee's LTD insurance issued on the basis of a Personal Health Statement? <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		
Did LTD insurance continue while on Family Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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 \$ _____
Effective Date of Group Life Insurance coverage: _____	

D. Information Needed for Withholding and Reporting Taxes

What percent of this employee's LTD benefits is taxable? _____ %.
What percentage, if any, do you contribute towards the cost of the LTD premium? _____ %
Does the employee contribute towards the cost of the LTD premium? <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 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 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. Use these definitions for the frequency of occurrence: **Not Applicable** means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

Activity	Frequency of Occurrence			
	N/A	Occasionally	Frequently	Continuously
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reaching/working overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

_____ %

_____ %

_____ %

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.

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 _____

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



APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

Section II - Employee's Statement

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

A. Information about you

Last Name:	First Name:	Middle Initial:	Date of Birth:	Social Security Number:
Address: (Street, City, State & Zip Code)				Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Email Address: _____				
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"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Occupation: _____	
Your employer: (include division, if applicable)				
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: (Circle or check one)				
High School: 1 2 3 4 Trade School: _____ Current Occupational Licenses: _____				
College: 1 2 3 4 Masters: _____ Ph.D: _____				
Have you ever 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.)				
Job Title		Duties		Years Worked
(a)				
(b)				
(c)				
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)

Spouse's Name: (Last, First)			
Spouse's Social Security Number:	Date of Birth: (Month/Day/Year)	Is your 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 physician? (Month/Day/Year)	Name of Physician: Address of Physician:
---	---

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 your occupation? 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 _____ Full time _____
 (date) (date)

E. Information About Physicians and Hospitals

First medical attention for the current disability was given by (complete below)

Doctor's Name:	Telephone: () Fax: ()	Specialty:
Address: (Street, City, State & Zip)		Dates seen: _____ to _____

List all Physicians and Hospitals you have seen for this condition (attach separate sheet, if needed)

Doctor's Name:	Telephone: () Fax: ()	Specialty:
Address: (Street, City, State & Zip)		Dates seen: _____ to _____
Hospital:		
Address: (Street, City, State & Zip)		Dates of Confinement: _____ to _____

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

E. Information About Physicians and Hospitals (Cont...)

Have you consulted any other physicians or been hospitalized in the past three years? Yes No
 If "Yes," complete the following concerning your past treatment (attach separate sheet, if needed)

Doctor'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).

<u>Source of Income</u>	<u>Amount (week /month)</u>	<u>Date Claim was filed</u>	<u>Date Payments began</u>	<u>Date Payments ended</u>
Social Security/Retirement	\$ _____ / _____	_____	_____	_____
Social Security/Disability	\$ _____ / _____	_____	_____	_____
Sick Pay or Salary Continuation	\$ _____ / _____	_____	_____	_____
Income from Work	\$ _____ / _____	_____	_____	_____
Workers' Compensation	\$ _____ / _____	_____	_____	_____
State Disability	\$ _____ / _____	_____	_____	_____
Pension/Retirement	\$ _____ / _____	_____	_____	_____
Pension/Disability	\$ _____ / _____	_____	_____	_____
Short Term Disability	\$ _____ / _____	_____	_____	_____
Unemployment	\$ _____ / _____	_____	_____	_____
No-Fault Insurance	\$ _____ / _____	_____	_____	_____
Other (include individual, Group, or Veteran's Benefits)	\$ _____ / _____	_____	_____	_____

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.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the 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 California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, 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 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, Virginia 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 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.

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.

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.

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

Signature

Date

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

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

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS



Section IV - Attending Physician's Statement of Disability (Page one)
To be completed by the Employee

Name of patient	Social Security Number	Date of Birth
Address of patient (Street, City, State & Zip Code)		
Employer's name (and division, if applicable)		
I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.		
Signed (Patient) _____		Date _____

To be completed by the Attending Physician
(The patient is responsible for the completion of this form without expense to the Company.)

Patient's condition is the result of: <input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> Pregnancy		Height	Weight
If pregnancy, what is the expected date of delivery? _____		If pregnancy, indicate LMP date: _____	
		Month / Day / Year	Month / Day / Year
Is condition due to illness, or an injury that is work related? <input type="checkbox"/> Yes <input type="checkbox"/> No			

DIAGNOSIS

Primary diagnosis:	ICD-9 Code:
Secondary diagnosis(es):	ICD-9 Code(s):
Test Results (list all results, or enclose test):	
Test: _____	Date: _____ Results: _____
Test: _____	Date: _____ Results: _____
Subjective symptoms:	
Physical examination findings:	

TREATMENTS

Date you first treated this patient: _____	Date you first treated this patient for this condition: _____
Date of onset of this condition: _____	Date of disability: _____ Date of most recent treatment: _____
How often has patient been seen/treated? _____	Date of next office visit: _____
Has patient been referred to any other physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Date(s) _____	
Name of physician	Specialty
Address of physician:	
Nature of treatment for this condition	
Has surgery been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Date: _____	
Procedure:	CPT Code:
Was patient hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Date(s) admitted _____	
Date(s) discharged: _____	
Name of hospital(s):	
Address of hospital(s):	
Progress (Please check one.): <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed	

FUNCTIONAL CAPABILITIES

Please complete this section **based on your clinical assessment at the time patient stopped working or reduced work schedule.**

In a general workplace environment the patient is able to:

	Sit	Stand	Walk
Number of hours at a time			
Total hours/day			

Please check the frequency with which the patient can perform the following activities:

	Never	Occasionally (1-33%)	Frequently (34-67%)	No Restrictions	Not Applicable
Lift / carry 1 to 10 lbs.	R L B	R L B	R L B	R L B	
Lift / carry 11 to 20 lbs.	R L B	R L B	R L B	R L B	
Lift / carry 21 to 50 lbs.	R L B	R L B	R L B	R L B	
Lift / carry 51 to 100 lbs.	R L B	R L B	R L B	R L B	
Lift / carry over 100 lbs.	R L B	R L B	R L B	R L B	
Bending at waist					
Kneeling / crouching					
Driving					
Reaching only (not load-bearing)	Above shoulder	R L B	R L B	R L B	R L B
	At waist / desk level	R L B	R L B	R L B	R L B
	Below waist / desk level	R L B	R L B	R L B	R L B
Fingering / handling	R L B	R L B	R L B	R L B	

Hand dominance: R L

Is the patient's vision impaired? Yes No

Best corrected visual acuity: R _____ L _____

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

Progress (Please check one): Recovered Improved Unchanged Retrogressed

Do you believe the patient is competent to endorse checks and direct the use of the proceeds? Yes No

Current restrictions or limitations, if different from above:

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

Attending Physician's Name: (please print or type)

Telephone Number:

()

License Number:

EIN Number:

Fax Number:

()

Degree:

Specialty:

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

Signature: _____ Date signed: _____

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY



ATTENDING PHYSICIAN'S STATEMENT OF CONTINUED DISABILITY

To be completed by the Employee

Patient Name: _____ Date of Birth: _____ Insured ID Number: _____
Patient Address: _____ City: _____ State: _____ Zip Code: _____
Personal Cell Telephone Number: () _____
May we have your authorization to leave confidential medical and benefit information on your personal cell phone? Yes No
Alternate Telephone Number (if no personal cell telephone): () _____
I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.
Signed: _____ Date: _____

To be completed by the Attending Physician - 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.)

DIAGNOSIS

Primary diagnosis: _____ ICD-9 Code: _____
Secondary diagnoses: _____ ICD-9 Code(s): _____
Current Subjective Symptoms: _____
Current Physical Examination findings: _____
Current Blood Pressure: _____ Height: _____ Weight: _____ Weight Loss or Gain? _____
Current Pertinent Test Results (Not previously reported; List all results, or enclose test result reports):
Test: _____ Date: _____ Results: _____
Test: _____ Date: _____ Results: _____
Current Medications, Dosage, and Frequency (indicate any changes): _____

TREATMENT PLAN

Current Treatment Plan: _____
What is the Frequency / Duration of Treatment? _____ Dates of Treatment: _____
First Office Visit for this condition: _____ Last Office Visit: _____ Next Scheduled Office Visit: _____
Has Surgery been performed since last report: Yes No If "Yes," on what Date(s): _____
Procedure(s): _____ CPT Code(s): _____
Was patient hospitalized since last report? Yes No If "Yes," Hospital name and phone Number: _____
Admission date: _____ Discharge date: _____
Has patient been referred to other physicians? Yes No If "Yes," Date of Referral(s): _____
Referral Physician Name _____ Phone Number() _____ Specialty: _____
Referral Physician Name _____ Phone Number: () _____ Specialty: _____

FUNCTIONAL CAPABILITIES

Please complete the applicable portion of this section based on your most recent clinical assessment.

In a general workplace environment the patient is able to:

	Sit	Stand	Walk
Number of hours at a time			
Total hours / day			

Please circle / check the frequency that the patient can perform the following activities:

R = Right	L = Left	B = Bilateral	Never	Occasionally (1-33%)	Frequently (34-67%)	No Restriction
Lift / carry 1 to 10 lbs.			R L B	R L B	R L B	R L B
Lift / carry 11 to 20 lbs.			R L B	R L B	R L B	R L B
Lift / carry 21 to 50 lbs.			R L B	R L B	R L B	R L B
Lift / carry 51 to 100 lbs.			R L B	R L B	R L B	R L B
Lift / carry over 100 lbs.			R L B	R L B	R L B	R L B
Bending at waist						
Kneeling / Crouching						
Driving						
Reaching only (not load-bearing)	Above shoulder		R L B	R L B	R L B	R L B
	At waist / desk level		R L B	R L B	R L B	R L B
	Below waist / desk level		R L B	R L B	R L B	R L B
Fingering / handling			R L B	R L B	R L B	R L B

Is the patient's vision impaired? Yes No If "Yes, please describe the extent of the impairment. _____

Best corrected vision: R _____ L _____

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

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

Do you believe the patient is competent to endorse checks and direct the use of the proceeds? Yes No

Can the patient participate in vocational rehabilitation services (this may include worksite accommodations, identifying alternative work, and or retraining assistance)? Yes No If "No," anticipated date they can participate: _____

PHYSICIAN INFORMATION

Provider's Name: _____ Telephone Number: () _____

Degree: _____ Specialty: _____ Fax Number: () _____

License Number: _____ Social Security Number or EIN Number: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Signature: _____ Date signed: _____