Job Accommodation Request

The Interactive Process

The Hartford is committed to ensuring all employees receive the support needed when they may have a medical condition that affects their ability to perform their job. Completion of this form is part of an interactive process that will allow The Hartford to assess your medical condition and to determine whether a job accommodation is appropriate. **Please follow the instructions below to begin this interactive process.**

1. Please complete Section A of this form and include your name at the top of each page. Provide your health care provider with both Sections A and B. Your health care provider is required to: (1) complete Section B, (2) make a recommendation for the accommodation(s) needed, and (3) attach the current and relevant medical records/documentation in support of the request.
2. Your health care provider will submit the fully completed form (Sections A and B) and medical documentation to The Corporate Medical Advisor by mail (My Wellness At Work Health Center, The Hartford, One Hartford Plaza, TB103, Hartford CT 06155) **or** by fax (1-855-272-5002) **or** by email (Jobaccommodation@thehartford.com).
3. Once we receive the fully completed job accommodation request, The Hartford will confirm by email that your request was received and is under review. Failure to complete this form or provide appropriate supporting medical documentation in a timely manner may delay evaluation of your request.
4. If you, or health care provider, submitted medical documentation/records to HartLeave related to your medical condition that may support this request, then you may give your consent to HartLeave to forward those records to the Corporate Medical Advisor.

Please note: The Hartford may request additional medical documentation or clarification if needed. It is your responsibility to obtain and provide the additional information to ensure your request can be appropriately reviewed.

The Hartford may approve the requested accommodation as presented, suggest one or more alternative modifications or deny the accommodation request. The Hartford reserves the right to request that an independent medical provider evaluate your condition before granting a request for a job accommodation.

If The Hartford approves a job accommodation for you, The Hartford,

- Reserves the right to request that your health care provider re-certify the need for the job accommodation at reasonable intervals; and
- Has not made any determination that you are disabled, as defined in the Americans with Disabilities Act or any other laws.

If you have questions during any part of the interactive process, please contact the Corporate Medical Department at Jobaccommodation@thehartford.com, submit an Employee Relations request through iConnect under HR Info, Employee Relations, Submit Request, or call The Hartford HR Service Center at 1-877-HR-AT-WORK (1-877-472-8967)

This process only applies to employees of The Hartford and Pontoon contractors. Non-employees, vendors or other contractors should contact their employer for information regarding reasonable accommodations.

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SECTION A: To be completed by employee and then provided to health care provider with Section B	
Employee's Name:	**Date:**
Employee's Date of Birth:	**Employee ID:**
Job Title & Tier:	**Short Description of Role:**
Supervisor Name:	**Employee's Personal Email Address:**
Are you currently on FML or STD/LTD? **FML:** Yes ☐ No ☐ **STD/LTD:** Yes ☐ No ☐ If yes, start date of leave: _____	**Current Work Status:** ☐ 100% Remote ☐ 100% In-office ☐ Hybrid If hybrid, # of days in office per week: _____

Authorization to Release Medical Information:

- Current and relevant medical records should be submitted in support each request. The Hartford does not condition evaluation of your job accommodation request on whether you sign this Authorization. However, failure to receive supporting medical documentation from your health care provider may delay your request.
- You have the right to a signed copy of this Authorization.
- You can revoke this Authorization at any time by submitting a written revocation to the address at the bottom of this form.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be disclosed again by the recipient and the information may no longer be protected.

I hereby authorize the following health care provider(s):

☐ _____

And/Or

☐ HartLeave – The Hartford's administrator of STD/LTD and FML claims – by checking this box, you authorize HartLeave to share medical information that you provided to HartLeave in support of your claim(s) for STD/LTD or FML.

To release to The Hartford's Corporate Medical Advisor relevant health information relating to my health condition for which I am requesting a job accommodation. The Hartford's Corporate Medical Advisor may use this information only to facilitate the evaluation or resolution of my request for a job accommodation. This authorization will terminate on the earlier of (i) the disposition (either approved or denied) of my request for a job accommodation; or (ii) my termination of employment from The Hartford.

Employee Signature:	**Date:**

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SECTION B: To be completed by your health care provider with detailed responses and returned to The Hartford's Corporate Medical Advisor with supporting medical documentation.([1])([2])	
1. **Employee's Name:**	
2. **Is this a chronic or a temporary condition? If temporary, what is the expected duration?**	
3. **What is the current prescribed treatment for the above condition?**	
4. **Does the employee's medical condition affect his/her ability to perform his/her job? If so, please explain.**	
5. **Please provide your medical opinion as to what possible job accommodation or restrictions, if any, (e.g., special equipment needs, time away from work, etc.) would allow the employee to perform the duties of his/her job. Please provide recommendations.**	
6. **Explain why this accommodation is medically necessary.**	
7. **Please indicate the duration for the recommended accommodation or restrictions.** Start date: _____ End date: _____	
8. **Please indicate when the employee will be re-evaluated.**	
Health Care Provider's Name:	**Signature:**
Mailing Address:	**Date:**

(1) 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 member's genetic tests, the fact that an individual or an individual's 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.

(2) Please note that neither you nor your health care provider are required to disclose your diagnosis or the underlying medical cause of your alleged disability.

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Provider's Email Address:	**Provider's Telephone Number:** **Provider's Fax Number:**

Please label as **"Medical Confidential"** and then forward all pages of this completed form (Sections A and B), the job description (if provided), and supporting medical records/documents to The Hartford's Corporate Medical Advisor:

By fax: 1-855-272-5002

or

By mail:
My Wellness At Work Health Center, The Hartford
One Hartford Plaza, TB103
Hartford, CT 06155

or

By email: Jobaccommodation@thehartford.com

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