GROUP LIFE - Waiver of Premium / Permanent Total Disability (PTD) / Disability Extension Claim Form

INSTRUCTION PAGE

Claim form to waive premium on Group Life Insurance for covered employees who have become disabled and are unable to work.

Why apply for Group Life Waiver of Premium?

If employees become disabled as defined by their Group Life plan, the Waiver of Premium benefit, featured on many of The Hartford's Group Life Insurance policies, offers a safeguard against losing valuable Group Life coverage. For employees who apply and are approved, no Group Life premiums are due after the Waiver of Premium waiting period has been satisfied, and coverage continues in accordance with the policy provisions. ****Reminder** Group Life Premiums are due and payable during the Waiver of Premium waiting period unless the employee has already converted coverage to an individual policy.**

EMPLOYEE'S RESPONSIBILITY - SECTION 1

1. Complete Employee Section 1 - pages 1 and 2.

2. Read, sign and date the Important Notice, Employee Section 1 - page 3.

3. Read and complete Employee Section 1 - page 4. Sign and date the Authorization at the bottom of the Employee Section 2 - page 4.

4. On the *Attending Physician's Statement of Disability*, complete and sign the Employee information and authorization at the top of the Attending Physician's Statement - page 1. Remove the *Attending Physician's Statement of Disability Section* (Attending Physician's Statement) - pages 1 through 4 from this claim form and give it to the physician certifying your disability. Ask your physician to complete the form and return it within 10 days to The Hartford. Be aware that you are responsible for any fees charged by your physician for completion of this form.

5. SUBMIT THIS APPLICATION BEFORE THE 12-MONTH DEADLINE* To qualify for benefits, submit the completed Employee Sections and all attachments, by the deadline* specified in your Group Life plan. Make a copy to keep with your records. The *Attending Physician's Statement* should be sent separately by the physician before the same deadline.

6. Please follow up to make sure that this claim form, all attachments, and the *Attending Physician's Statement of Disability* are received by The Hartford within the deadline* specified in your Group Life plan

SEND THE CLAIM FORM TO:

THE HARTFORD
Group Benefit Claims
P.O. Box 14296
Lexington, KY 40512-4296

OR FAX TO:

Group Benefit Claims
(877) 467-3037

For questions about how to complete this form call The Harford Toll-free at **1-866-712-3443**

***The deadline for submission is usually 12 months from the employee's date last worked; check your plan to verify.**
Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly.

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EMPLOYEE SECTION 1

This is a time-sensitive document

***Submission deadline is usually 12 months from the last day of work; check your plan.**

Group Policy Number: ______________________

Employer Name: ______________________

Be sure to answer all questions - missing information may delay your claim.

A. INFORMATION ABOUT YOU

Name: ☐ Male ☐ Female

Address:

Personal Cell Phone Number: (   ) ________ Alternate Telephone Number: (   ) ________ E-Mail address: ________

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No

Signature: ______________________ Date: ________

At the time your TOTAL disability began, were you working more than one job (including self-employment)? ☐ Yes ☐ No
If "Yes," provide the name, address and phone number of other employers and indicate the dates when you worked (or were self-employed).

Please indicate your educational history: (Check or Circle last year completed.)

Education through High School 1 2 3 4

College 1 2 3 4 ☐ Masters ☐ Ph.D.

Are you now attending school? ☐ Yes ☐ No

Trade or technical school: (Describe course of study.)

____

____

____

Describe your last four jobs. (Begin with your most recent job.)

	Company	Job Title	Duties	Years
(a)				
(b)				
(c)				
(d)				

Are you receiving any income from other sources?

	Amount	Name	Address	Phone
Short Term / Long Term Disability	$			( )
Workers' Compensation	$			( )
Individual Disability	$			( )
Self-employment or Part-time work	$			( )

B. INFORMATION ABOUT THE CONDITION CAUSING YOUR DISABILITY

Describe your medical condition: ____________________

Why did you stop working? ____________________

If caused by an illness, have you had this illness before? ☐ Yes ☐ No If "Yes," when? ____________

If caused by an injury, when, where and how did the injury occur? ____________________

Date you were first treated by a Medical Provider for the disabling illness or injury: ____________

Name of Medical 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 the cause of your condition related to your job? ☐ Yes ☐ No If "Yes," explain: ____________________

What important duties of your job are you unable to perform? ____________________

Are you now engaged in the duties of any occupation or endeavor for wages, profit, compensation or volunteerism? ☐ Yes ☐ No

C. INFORMATION ABOUT YOUR DISABILITY

Last day you physically reported to work: ____________ Since that date, have you done any work? ☐ Yes ☐ No
If "Yes," please indicate dates worked, name and address of employer and amount earned.

Have you returned to work in any capacity? ☐ Yes ☐ No If you have not returned to work, do you expect to? ☐ Yes ☐ No

If "Yes," part-time *(date)* ____________ full-time *(date)* ____________

D. INFORMATION ABOUT YOUR PHYSICIANS

List all physicians you have seen for this condition *(attach a separate sheet if needed)*

Doctor's Name	Specialty	Dates seen
Address		
City/State/Zip Code	( ) Telephone Number	( ) FAX Number

Doctor's Name	Specialty	Dates seen
Address		
City, State, Zip Code	( ) Telephone Number	( ) FAX Number

Doctor's Name	Specialty	Dates seen
Address		
City, State, Zip Code	( ) Telephone Number	( ) FAX Number

IMPORTANT NOTICE

E. EMPLOYEE'S SIGNATURE

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

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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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 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 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 Group Life Waiver of Premium / Permanent Total Disability / Disability Extension Application are true and complete to the best of my knowledge and belief.

________________________________ ________________

Signature Date

THE HARTFORD

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To: Any health care provider, employer, benefit plan, insurer, service provider, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to The Hartford[1] a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

Insured's Name (*Please print*)	Date of Birth	Last 4 Digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental, or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits and bank records; business transactions billing, invoice, and payment records; academic transcripts; and information concerning Social Security 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 for the purpose of evaluating and administering my claim for benefits and/or leave request. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

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. I authorize The Hartford to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to complaints by me or my representative relating to benefits or leave; d) responding to any litigation or agency document production request or lawful subpoena; e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers of my employer's benefit plan, other benefits, and/or leave programs of my employer for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan 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 or reinsurance purposes, including workers' compensation insurance; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; or (ix) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make, unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. 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 or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian	Date	Relationship to Insured (*if signed by Guardian*)

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

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ATTENDING PHYSICIAN'S STATEMENT
This is a time-sensitive document

Submission deadline is usually 12 months from the last day of work; check your plan.

The employee is responsible for any physician fees for the completion of this form.
This section to be completed and signed by the Employee

Name of Patient

Address *(Street)*

(City/State/Zip Code)

( )
Telephone Number | Date of Birth | Social Security Number

Employer and Division *(if applicable)*

I hereby authorize my physician to release any information concerning my medical condition(s) for the purpose of claim processing.

Patient's Signature | Date

Physician's Instructions **Please respond within 10 Days**

A delay in returning a completed *Attending Physician's Statement* could result in your patient's being disqualified from receiving valuable Life Insurance benefits.

Please complete the remainder of this form for your patient. Sign and date the last page.

SEND THE COMPLETED FORM TO:
THE HARTFORD
Group Benefit Claims
P. O. Box 14296
Lexington, KY 40512-4296

OR FAX TO:
Group Benefit Claims
(877) 467-3037

If you have questions, call The Hartford Toll-free at 1-866-712-3443

This section to be completed by the Attending Physician

A. PATIENT INFORMATION

Height ________ Weight ________

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy ☐ Other

Is condition due to illness or an injury that is work related? ☐ Yes ☐ No

B. DIAGNOSIS

Primary diagnosis ________ ICD-9 Code ________

Secondary diagnosis(es) ________ ICD-9 Code ________

Concurrent/Co-morbid conditions(s) ________ ICD-9 Code ________

Subjective symptoms: ________

Objective findings: ________

C. TREATMENTS

Date you first treated this patient ____________ | Date you first treated this patient for this condition ____________

Date Patient was first advised to stop working due to Illness/Injury ________________

Date of onset of this condition __________________ Date of most recent treatment __________________

How often has patient been seen or treated?__________________________________ Date of next office visit. __________________

Has patient been referred to any other physician? ☐ Yes ☐ No
If "Yes":

Physician's name____ Physician's Telephone Number (____)____________________

Physician's address ____

Specialty____ Date of office visit __________________

Nature of treatment for this condition ____

Has surgery been performed? ☐ Yes ☐ No If "Yes", Date __________________

Procedure ____ CPT Code: ________________________________

____ ________________________________

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes,"

Name and address of hospital(s)____

Date(s) admitted __________________ Date(s) discharged__________________

Progress (please check one) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

D. PHYSICAL IMPAIRMENTS

1. Indicate the extent to which the patient's ability to perform any of the following activities is limited by his or her disorder. In an 8-hour workday, the patient can *(Circle or check number of hours)*:

Sit for 0 1 2 3 4 5 6 7 8 hours at a time Stand for 0 1 2 3 4 5 6 7 8 hours at a time

Walk for 0 1 2 3 4 5 6 7 8 hours at a time Drive for 0 1 2 3 4 5 6 7 8 hours at a time

2. Check the maximum limit and frequency that the patient can lift/carry:

	Never	Occasionally	Frequently	Constantly
1-10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100 lbs.	☐	☐	☐	☐
over 100 lbs.	☐	☐	☐	☐

D. PHYSICAL IMPAIRMENTS (cont'd)

3. Check the maximum limit and frequency that the patient can lift/carry:

	Never	Occasionally	Frequently	Constantly
Climbing	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Reaching				
Above shoulder	☐	☐	☐	☐
Below waist level	☐	☐	☐	☐
At waist level	☐	☐	☐	☐
Handling	☐	☐	☐	☐
Fingering	☐	☐	☐	☐
Feeling	☐	☐	☐	☐

4. Indicate the patient's capacity for repetitive use of feet and hands.

Right hand ☐ Yes ☐ No   Left hand ☐ Yes ☐ No   Both hands ☐ Yes ☐ No

Right foot ☐ Yes ☐ No   Left foot ☐ Yes ☐ No   Both feet ☐ Yes ☐ No

4a. Dominant hand (check one) ☐ Right ☐ Left

5. If any other activities are limited, please specify the activities and the limitations

6. If the patient's vision is impaired, please describe the extent of the impairment ____________________

Date vision test was performed ____________________ Visual Acuity:

	R	L
Corrected		
Non-Corrected		

7. From the following classifications of work strength requirements, please describe the exact degree of work you feel this patient is capable of performing*: ____________________

☐ **Sedentary Work:** Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles such as dockets, ledgers and small tools. A job is considered sedentary if it involves primarily sitting, and requires only occasional walking and standing.

☐ **Light Work:** Lifting 20 lbs. with frequent lifting and/or carrying of objects weighing up to 10 lbs. A job is considered Light Work if it involves sitting most of the time with a degree of pushing and pulling or use of arm and/or arm controls; or when it requires walking or standing to a significant degree.

☐ **Medium Work:** Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.

☐ **Heavy Work:** Lifting 100 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 50 lbs.

☐ **Very Heavy Work:** Lifting more than 100 lbs. with frequent lifting and/or carrying of objects weighing 50 lbs or more.

***Five degrees of work are taken from the Dictionary of Occupational Titles, Volume II, pages 654-655, published by the U.S. Dept of Labor (3rd ed. 1965)**

8. Are there environmental workplace restrictions for this patient as a result of the patient's impairment? ☐ Yes ☐ No
"If Yes," describe:

9. CARDIAC (complete if disability is due to heart condition) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitations)

Remarks: ____________________

E. PSYCHIATRIC IMPAIRMENTS (if applicable)

What problems with stress or interpersonal relations has the patient had on the job? Indicate the degree to which the patient is able to perform the duties of their occupation.

☐ **Class 1 - No Limitations:** Patient is able to function under stress and engage in interpersonal relations.

☐ **Class 2 - Slight Limitations:** Patient is able to function in most stress situations and engage in only limited interpersonal relations.

☐ **Class 3 - Moderate Limitations:** Patient is able to engage in stress situations or engage in only limited interpersonal relations.

☐ **Class 4 - Marked Limitations:** Patient is unable to engage in stress situations or engage in interpersonal relations.

☐ **Class 5 - Severe Limitations:** Patient has significant loss of psychological, physiological, personal and social adjustment.

Do you believe the patient is competent to endorse checks and manage the proceeds appropriatley? ☐ Yes ☐ No

Remarks: ______________________________

GAF Score: ______________ Date: ______________

What are the stressors? ______________________________

Job Related? ☐ Yes ☐ No

F. OUTLOOK

Has the patient reached maximum medical improvement ☐ Yes ☐ No

Date patient can return to work at his/her regular job: ______________
Month Day Year

Specify: ☐ Without restrictions
☐ With restrictions, as noted

Date patient can return to work at a different job in a lighter duty capacity ______________
Month Day Year

How long do you expect the restrictions and limitations from any work to continue? ______________

G. PHYSICIAN INFORMATION

Physician's Name: ______________ Social Security Number or EIN ______________

Address: *(Street, City, State, Zip Code)* ______________

Specialty ______________ Licence Number ______________ ( ) Telephone Number ______________ ( ) Fax Number ______________

Physician's Signature ______________ Date ______________

PLEASE ATTACH OFFICE NOTES, CONSULTATION REPORTS, OR ANY DIAGNOSTIC TESTS THAT ILLUSTRATE CURRENT LIMITATIONS AND RESTRICTIONS.