



ITT HARTFORD

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

**APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS**

This application package is divided into four sections, as follows:

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

Return Form To:

Department of Transportation  
Attention: Trina Brown  
Burns Building, Mail Station 50  
605 Suwannee Street  
Tallahassee, FL 32399-0450

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



HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Employer's Statement

To be Completed by the Employer

This claim is for ( <i>Employee's Name</i> )	Social Security Number	Date of Birth
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Employee's Address (*Street, City, State, Zip*):

A. Information about the employer

Company's Name	Group Policy Number
Address ( <i>Street, City, State, Zip</i> )	Telephone Number
Name and address of division where employee works ( <i>if different from above</i> ):	Fax Number

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
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Was the employee's LTD insurance issued on the basis of a Personal Health Statement?  Yes  No If "Yes," attach copy.

Was the employee insured under your prior LTD policy?  Yes  No  
If "Yes," please provide the inclusive date of coverage: From \_\_\_\_\_ through \_\_\_\_\_

Has the employee been terminated?  Yes  No If "Yes," date: \_\_\_\_\_  
Reason:

Was the employee on Qualified Family Leave when disability began?  Yes  No  
Did LTD insurance continue while on Family Leave?  Yes  No  
Date Leave of Absence started under Family Leave Act? \_\_\_\_\_

C. Information needed for withholding and reporting taxes

Based on the employer/employee premium contributions made over the last 3 calendar years, what percentage of the LTD benefits is considered taxable? \_\_\_\_\_ %. (See Section 7 of IRS Publication 15-A for information on determining the taxable percentage.)

D. 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?  
 Yes  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 had the employee been in this job? \_\_\_\_\_

Last day employee actually worked? \_\_\_\_\_ On that day, did the employee work a full day?  
 Yes  No If "No," how many hours were worked? \_\_\_\_\_

Why did employee stop working? \_\_\_\_\_ Is the employee's condition work related?  
 Yes  No

Has a claim been filed with Workers' Compensation?  
 Yes  No If "Yes," send initial report of illness or injury and award notice.

Name and address of your compensation carrier:

E. Information about your pension plan (*Do not complete for maternity claim.*)

Do you have a pension plan?  Yes  No  
If "Yes," what type?  Defined benefit  401 K  Other (specify) \_\_\_\_\_  
*(Check as many as applicable.)*  Defined contribution  Profit Sharing

Is the employee eligible for your pension plan?  
 Yes  No If "No," why? \_\_\_\_\_  
If eligible, does the employee participate?  
 Yes  No If "No," why? \_\_\_\_\_

If the employee is participating, when is he or she eligible for benefits under the plan? \_\_\_\_\_  
*(Month, Day, Year)*

At what point does the employee qualify for a full pension? \_\_\_\_\_

Is there a Disability Retirement Option available to this employee?  Yes  No

**F. 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?

**G. Information about the employee's salary**

Basic Salary or wage immediately prior to cessation of work because of disability (exclude bonuses, overtime, pay, etc.)  
 \$ \_\_\_\_\_  Monthly  Weekly  Annually  Hourly # Hours/Week \_\_\_\_\_

Is this employee eligible for salary continuation?  
 Yes  No If "Yes," what is the 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:

**H. 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"/>
<input type="checkbox"/> Stairs				
Number of stairs:				
<input type="checkbox"/> Ladders				
Height of ladder:				
<input type="checkbox"/> Pushing				_____ lbs.
<input type="checkbox"/> Pulling				_____ lbs.
<input type="checkbox"/> Lifting/carrying				_____ lbs.

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?

\_\_\_\_\_ %  
 \_\_\_\_\_ %  
 \_\_\_\_\_ %

**I. 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:

**J. Required attachments and Signature**

Please attach a copy of the employee's job description.  
 If the employee contributes to the premiums, 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

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS  
**HARTFORD LIFE INSURANCE COMPANY**  
**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

**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 \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address (Street) \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_

Date of Birth (Month, Day, Year) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Male  Single  Widowed  
 Female  Married  Divorced

Your employer (include division, if applicable) \_\_\_\_\_ Occupation \_\_\_\_\_

When your disability began, did you have more than one employer?  Yes  No. If "Yes," please provide the name, address and phone number of that employer, and indicate the dates when you worked.

Please indicate the extent of your formal education (Circle one)

High School: 1 2 3 4 5 6 7 8 9 10 11 12

College: 1 2 3 4

Masters \_\_\_\_\_ Ph.d. \_\_\_\_\_

Trade School: \_\_\_\_\_

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)		
(d)		

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work?

Yes  No

Have you contacted your State Department of Vocational Rehabilitation?

Yes  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?  Yes  No Retired?  Yes  No

Do you have any children under Age 19?

Yes  No If "Yes," name and date of birth of your youngest child.

Do you have any handicapped children (regardless of age)?

Yes  No If "Yes," name and date of birth of each child.

**C. Information about the condition causing your disability**

**1. For illness, answer the following questions:**

What were your first symptoms?

When did you first notice them?

Have you had this illness before? If so, when?

**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?

Name of Physician \_\_\_\_\_

\_\_\_\_\_  
(Month Day Year)

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?

Did you work a full day?  Yes  No  
If "No" explain.

Date you were first unable to work?

\_\_\_\_\_  
(Month Day Year)

\_\_\_\_\_  
(Month Day Year)

Since that date, have you done any work?  Yes  No

If "Yes," please indicate dates worked, name of employer, and amount earned.

If you have not returned to work, do you expect to?

Yes Part time (date) \_\_\_\_\_ Full time (date) \_\_\_\_\_  
 No

**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** (attached 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

**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

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 or Group Benefits)	\$ ____ / _____	_____	_____	_____

**G. Information about Tax Withholding**

If your request for benefits is approved, should ITT Hartford withhold Federal Income Tax from your benefit checks?

Yes  No

If "Yes," how much should be withheld from each monthly check? (Minimum is \$87.00 per month.) \$ \_\_\_\_\_ .00

**H. Signature**

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With the exception of any source(s) of income reported above in Section F of this form, I certify by my signature that I have not and am not eligible to receive any source of income, except for my ITT Hartford Disability Income. Further, I understand that should I receive income of any kind or work of any kind during any period ITT Hartford has approved my disability claim, I must report all details to ITT Hartford, immediately.

If I receive disability benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company 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, Florida, New Jersey, and 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 thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a substantial civil penalty where and to the extent of the law.

**For residents of Florida: Subject to Section 817.234(b):** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete or misleading information commits a felony of the third degree.

**For residents of New Jersey: Subject to Section 17:33 a-6(a):** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**For residents of Pennsylvania: Subject to Section 4117:** 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.

**FOR RESIDENTS OF CALIFORNIA: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.**

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

X \_\_\_\_\_  
*SIGNATURE OF THE EMPLOYEE*

X \_\_\_\_\_  
*DATE*

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



**Authorization to Obtain Information**

**Section III**

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies;  
  
any employer, group policyholder, contract holder or insurer, benefit plan administrator, Medical Information Bureau, Inc., Health Claims Index, consumer reporting agency, financial institution; or  
  
any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize you to release and send to Hartford Fire Insurance Company; Hartford Life Insurance Company; Hartford Life and Accident Insurance Company, and all affiliates known collectively as ITT Hartford, or to ITT Hartford's representatives, a complete copy of any and all of the following information, records or documents relative to

\_\_\_\_\_ Insured's Name *(Please print.)*  
  
\_\_\_\_\_ (Date of Birth) \_\_\_\_\_ (Social Security Number)

1. Any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations, and treatment notes. For purposes of this authorization, medical information specifically includes all confidential HIV information, confidential communicable disease information, confidential alcohol or drug abuse information and confidential mental health information as such information may relate to my claim for benefits.
2. Employment information and history, including job duties and earnings; information on other insurance coverage and other claims filed, including all records and information related to such other claims; financial information; Federal or State tax returns.
3. Information concerning Social Security benefits, including monthly benefit amounts, monthly Supplemental Security Income payment amounts, entitlement dates, and information from my Master Benefits Record.

I understand that the information obtained by use of the Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by ITT Hartford to any person or organization EXCEPT to reinsuring companies, Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I may request to receive a copy of this Authorization.

This Authorization is given in connection with a claim for insurance benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

\_\_\_\_\_  
Signature of Insured or Guardian

\_\_\_\_\_  
Relationship to Insured *(if signed by Guardian)*

\_\_\_\_\_  
Date



HARTFORD LIFE INSURANCE COMPANY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Attending Physician's Statement

To be completed by the Employee

Name of patient \_\_\_\_\_ Social Security Number \_\_\_\_\_ D.O.B \_\_\_\_\_

Address of patient \_\_\_\_\_  
Street City State or Province Zip Code or Postal 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:  Illness  Injury  Pregnancy Height \_\_\_\_\_ Weight \_\_\_\_\_

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

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

DIAGNOSIS

Primary diagnosis (including any complications): \_\_\_\_\_

Secondary diagnosis(es): \_\_\_\_\_

ICD-9 codes: \_\_\_\_\_

Subjective symptoms: \_\_\_\_\_

Test Results (list all results, or enclose test):

Test: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Test: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Physical examination findings: \_\_\_\_\_

If pregnancy, indicate LMP date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

TREATMENTS

Date you first treated this patient: \_\_\_\_\_ Date you first treated this patient for this condition: \_\_\_\_\_

Date of onset of this condition: \_\_\_\_\_ Date of most recent treatment: \_\_\_\_\_

How often has patient been seen/treated? \_\_\_\_\_

Has patient been referred to any other physician?  Yes  No Date(s): \_\_\_\_\_

If "Yes," name and address: \_\_\_\_\_

Specialty: \_\_\_\_\_

Nature of treatment for this condition (including surgery, medications): \_\_\_\_\_

Was patient hospitalized for this condition?  Yes  No If "Yes," date(s) admitted: \_\_\_\_\_

Name and address of hospital(s): \_\_\_\_\_

Progress (Please check one.):  Recovered  Improved  Unchanged  Retrogressed

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

PART 3 - ATTENDING PHYSICIAN'S STATEMENT (Side two)

IMPAIRMENT

If the patient's ability to perform any of the following activities is limited by his/her disorder, please describe the extent of the limitation and its expected duration.

Standing: \_\_\_\_\_

Walking: \_\_\_\_\_

Sitting: \_\_\_\_\_

Lifting/carrying: \_\_\_\_\_

Reaching/working overhead: \_\_\_\_\_

Pushing: \_\_\_\_\_

Pulling: \_\_\_\_\_

Driving: \_\_\_\_\_

Keyboard use/repetitive hand motion: \_\_\_\_\_

If any other activities are limited, please specify the activities and the limitations: \_\_\_\_\_

If the patient's vision is impaired, please describe the extent of the impairment: \_\_\_\_\_

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

What is the psychiatric impairment? (if applicable)

- Class 1 — Able to function under stress and engage in interpersonal relationships (no limitations)
- Class 2 — Able to function in most stressful situations and engage in most interpersonal relations (slight limitations)
- Class 3 — Able to function in only limited stressful situations and only limited in interpersonal relations (moderate)
- Class 4 — Unable to engage in stressful situations or in interpersonal relations (marked limitation)
- Class 5 — Significant loss of psychological, physiological, personal and social adjustment (severe adjustment)

Date patient became unable to work due to this impairment? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

If limitations exist, how long do you feel limitations will last? \_\_\_\_\_

Attending Physician's Name: \_\_\_\_\_ Telephone # \_\_\_\_\_  
(Please print or type.)

License No. \_\_\_\_\_ FAX # \_\_\_\_\_

SS# or E.I.N.#: \_\_\_\_\_ Degree: \_\_\_\_\_ Specialty: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_