



Employer Group Benefits Coverage Information

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Please completely fill out **Section 1 and Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Employees: Please completely fill out the **Applicant Information section on the 2nd page** even if you are not applying for coverage.

Section 1: Employer Details (to be completed by Employer)

PLEASE PRINT CLEARLY

Employer Name:	Policy Number:
Employer Mailing Address (Street, City, State, Zip Code):	
Division/Location/Subsidiary with Mailing Address (<i>if applicable</i>):	
Benefits Contact Name (First, Last):	
Benefits Contact Email Address:	Benefits Contact Phone:

Section 2: Employee Details (to be completed by Employer)

PLEASE PRINT CLEARLY

Employee Name (First, MI, Last):	Date of Hire (mm/dd/yyyy):
Base Annual Earnings*:	Coverage Effective Date* (mm/dd/yyyy):

* As described in the contract with The Hartford

Life Insurance Coverage Requested

- Enter the dollar amount of **Current Life Coverage, including Guarantee Issue (GI)***. Please include Employee Basic Life coverage even if the employee is not requesting coverage at this time
- Enter the dollar amount of **Life Coverage Subject to Evidence of Insurability (EOI)**

* GI is the maximum amount of coverage as defined in the contract with The Hartford that does not require EOI

Current Life Coverage, including GI		Life Coverage Subject to EOI
Employee Basic Life	\$	\$
Employee Supplemental or Voluntary Life	\$	\$
Spouse Basic Life	\$	\$
Spouse Supplemental or Voluntary Life	\$	\$
Child Supplemental or Voluntary Life		
<ul style="list-style-type: none"> Check Yes if employee is requesting Child Life coverage that is subject to EOI Indicate the number of children applying: _____ 		<input type="checkbox"/> Yes, EOI is required

Disability Insurance Coverage Requested

- Check Yes if employee is requesting Short Term and/or Long Term Disability coverage that is subject to EOI

Short Term Disability	<input type="checkbox"/> Yes, EOI is required
Long Term Disability	<input type="checkbox"/> Yes, EOI is required

Critical Illness Insurance Coverage Requested

- Enter the dollar amount of **Current Critical Illness Coverage, including GI**
- Enter the dollar amount of **Critical Illness Coverage Subject to EOI**

Current Critical Illness Coverage, including GI		Critical Illness Coverage Subject to EOI
Employee Voluntary Critical Illness	\$	\$



EVIDENCE OF INSURABILITY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155

Applicant Information

If there are more than three Applicants, please provide the information on a separate sheet of paper.

First Name	Last Name	Social Security #	Gender	Height (ft./in.)	Weight (lbs.)*	Date of Birth (mm/dd/yyyy)
Employee			<input type="checkbox"/> Male <input type="checkbox"/> Female			
Spouse			<input type="checkbox"/> Male <input type="checkbox"/> Female			
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female			

* If currently pregnant, please provide pre-pregnancy weight

Employee	Street Address		Day Time Phone	
	City		Evening Phone	
	State, Zip Code		Email Address	

Spouse	Street Address		Day Time Phone	
	City		Evening Phone	
	State, Zip Code		Email Address	

Spouse's Address is the same as the Employee's

Child	Street Address		Day Time Phone	
	City		Evening Phone	
	State, Zip Code		Email Address	

Child's Address is the same as the Employee's

Medical Information

Each Applicant must answer each of the following questions to the best of their knowledge and belief. A Legal Guardian is required to answer each of the questions for minor children. If you have more than 1 child, specify which child(ren) the answer applies to on a separate sheet of paper.

	Employee	Spouse	Child
Within the past 5 years, have you been diagnosed with or treated by a licensed medical physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 consecutive work days due to a disability, injury, or sickness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the past 5 years, have you used any controlled substances, with the exception of those taken as prescribed by your physician, been diagnosed or treated for drug or alcohol abuse (excluding support groups), or been convicted of operating a motor vehicle while under the influence of drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for:

	Employee	Spouse	Child		Employee	Spouse	Child
Heart Disease (Do not check "Yes" if you only have High Blood Pressure or a Heart Murmur)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease, injury or surgery of Joint, Ligaments, Knee, Back, or Neck (including Arthritis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart-Related Surgery or Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure If you checked "Yes" to High Blood Pressure, have you had a change in medication within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Do not check "Yes" for Hepatitis A) or Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blocked Arteries (Arteriosclerosis, Atherosclerosis, Aneurysm, or Deep Vein Blood Clot)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke or transient ischemic attack (TIA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's or Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Major Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Fatigue Syndrome or Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Narcolepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer (Do not check "Yes" for Basal Cell Carcinoma only) If "Yes", Date of Diagnosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcerative Colitis or Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychotic, Psychiatric, Personality, or Bi-Polar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Failure or Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Notice

To the best of your knowledge, you are required to notify Hartford Life and Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date the coverage is approved.

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, copies of medical records which you have authorized us to review, and information obtained from MIB, Inc. Only information that is relevant to determining Evidence of Insurability for the coverage which you are currently requesting will be considered.

Authorization

I, an undersigned applicant, authorize Hartford Life and Accident Insurance Company, together with its affiliates, ("Company") to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

In the event that I cannot be reached via telephone, I authorize a representative of the Company to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that he or she is calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company by telephone.

Yes, you may leave a message as indicated above. No, please do not leave a message.

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize my employer, any health or benefits plan, physician, medical professional, hospital, clinic, laboratory, MIB Group, Inc. (MIB, Inc), pharmacy or pharmacy benefits manager that possesses my protected personal health information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), to furnish such protected health information to the Company or its representative. The Company may only use information disclosed under this authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

I authorize the Company to disclose the "PHI" in its files to its reinsurer(s) and affiliates, other insurance companies and their affiliates, other persons, representatives and/or organizations performing functions on behalf of the Company and their affiliates, my employer, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me that relates to this application and that such requested information and the identity of the source of the information shall be released to me or, in the case of medical information, to a licensed medical professional of my choice.

I/We authorize Hartford Life and Accident Insurance Company, or its reinsurers, to make a brief report of my/our personal health information to Medical Information Bureau.

I agree that a photocopy of this authorization is valid as the original and I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This authorization shall be valid for twenty-four (24) months from the date signed below. This authorization may be revoked upon written request to the Company, and will not remain valid beyond the date the revocation is received by the Company. I understand the revocation may be a basis for denying my insurance application, and that it does not alter the Company's right to use the application for purposes of determining misrepresentation once coverage has been issued.

I have received and read a copy of the Notice of Insurance Information Practices.

Fraud

For any Applicants that do not reside in the following states: Colorado, California, 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 may be 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: The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with the actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 or 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 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New York (Applicable to Accident and Health Insurance Only): 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 with the penalty of 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.

For residents of Virginia: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED STATE LAW.

PRE-EXISTING CONDITIONS LIMITATION – Applicable to Accident and Health Insurance Only – For Residents of NY

With respect to group disability insurance, I understand that the policy/certificate may include a pre-existing condition provision that limits or excludes coverage for a period of time if I have a pre-existing condition as defined on the date my coverage becomes effective. I also understand that I may obtain additional information regarding this provision by referring to the group policy and/or certificate.

Certification

For residents of Virginia only: I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

This application will be made a part of the Policy.

Employee Signature	/ /	Date Signed	Spouse Signature	/ /	Date Signed
Child Signature (Parent/Legal Guardian of the Child is required to sign when submitting dependent Evidence of Insurability on a minor child.)	/ /	Date Signed			

Please mail the completed **Employer Group Benefits Coverage Information** page and **Evidence of Insurability** application to:

The Hartford , Medical Underwriting
P.O. Box 2999
Hartford, CT 06104-2999

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@thehartford.com.

Questions? Call 1-800-331-7234

Employee First Name:

Last Name:

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza, Hartford, CT 06155

Authorization to Disclose Protected Health Information

To Be Used To Determine Eligibility for Group Life and/or Disability Income Coverage

I have applied for insurance under a Group Life and/or Disability Policy issued by Hartford Life and Accident Insurance Company ("The Hartford"). To assess whether I am eligible for this insurance, and for the additional purposes listed below, The Hartford may require that I authorize disclosure of a copy of my Health Information. Although Group Life and Disability Income Coverage are not subject to the requirements of HIPAA, this authorization is intended to comply with the requirements under Section 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; 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 and its service providers, Health Information about me.

The Hartford and its service providers may disclose my Health Information to The Hartford's agents, employees, representatives and service providers. My Health Information means my entire medical file, including but not limited to: x-rays; photocopies of medical records, prescription information, 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, mental health, HIV/AIDS or sexually transmitted disease information protected by state or Federal Law, 5) Counseling or therapy. Health information also means information on the diagnosis and treatment of mental illness, but excludes psychotherapy notes as defined by HIPAA. I understand that the MIB will only disclose my Health Information to The Hartford.

The Hartford will use my Health Information obtained pursuant to this Authorization 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.

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 Health Information, as described above, without restriction. By signing this Authorization, I acknowledge that I understand the following:
- That my 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.
- That The Hartford only will use my Health 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 coverage I 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 anytime, 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.
- 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.

Applicant Name
(First, MI, Last)

Applicant Type
(Employee/Spouse)

Signature Date
(MM/DD/YYYY)