



**HARTFORD FIRE INSURANCE COMPANY  
HARTFORD LIFE INSURANCE COMPANY**

**APPLICATION FOR DISABILITY INCOME BENEFITS**

This Application is divided into three sections, as follows:

- Section I **Insured Statement** – to be completed by the Insured who is applying for Disability Benefits. The Insured's Statement and the attached Authorization must be completed, signed and dated.
- Section II **Employer's Statement** – to be completed by the law enforcement agency authorized representative.
- Section III **Attending Physician Statement** – to be completed by the physician who is treating the Insured at the time of disability.

Please see that all sections are fully completed and signed in order to avoid any delays in the processing of your claim for benefits. An incomplete application may delay the processing of your claim.

Please note: A completed application will begin the investigation into eligibility for benefits. Additional information may be required.

APPLICATION FOR DISABILITY INCOME BENEFITS



THIS FORM IS TO BE COMPLETED BY THE INSURED PERSON (Failure to answer all questions may delay your claim.)

**Section I This section is to be completed by the Insured Person**

Personal Information					
Last Name		First Name		M.I.	Social Security Number
Address Street		City		State/Province	Zip
Date of Birth (Month, Day, Year)	Sex (Please check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status (Please check one) <input type="checkbox"/> Married <input type="checkbox"/> Single		Policy AGP 1673	
<input type="checkbox"/> Telephone Number (Home) ( )	<input type="checkbox"/> Fax Number ( )	<input type="checkbox"/> Cell Number ( )	E-Mail address		

Please check above your preferred means of communication: Fax, Phone Number or E-Mail. Be sure your privacy manager allows messages to be left on your home telephone number. YOU MUST PROVIDE AT LEAST ONE TELEPHONE NUMBER.

**Answer the following questions:**

State fully the nature of your disability. (Advise which duties of your occupation you are unable to perform.)

What were your first symptoms?

When did you first notice them? (Month, Day, Year) Have you had this condition before?  Yes  No If so, when? (Month, Day, Year)

When, where and how did the injury occur? Please provide complete details

**Medical Information**

Name of Physician	Telephone Number ( )	Date you were first treated by a Physician? (Month, Day, Year)
Address of Physician (Street, City, State & Zip)	Fax Number ( )	Are you still seeing this Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No

The above information should include the name of the provider who took you off work, and the provider(s) who continue to treat you for your condition. If you have more than one provider, indicate here ( ✓ )  and provide information on the back of form.

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.

Have you filed, or do you intend to file a Workers' Compensation Claim?  Yes  No

**Information about the Disability**

Last date you worked before the disability (Month, Day, Year)	Date you were first unable to work: (Month, Day, Year)
Since that date have you done any work? <input type="checkbox"/> Yes <input type="checkbox"/> No (Month, Day, Year)	
If you have not returned to work, do you expect to? <input type="checkbox"/> Yes <input type="checkbox"/> No Part-time (Month, Day, Year) Full-time (Month, Day, Year)	
Normal work hours per week	Current work status (Please check one) <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> Retired

**Signature**

The statements contained in this Application for Disability Income Benefits are true and complete to the best of my knowledge and belief. I understand that should I perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford immediately.

Signature of the Insured: \_\_\_\_\_ Date: \_\_\_\_\_

**Law Enforcement Information****Section II**

Law Enforcement Agency

Contact Person:

Address (Street)

Telephone Number

( )

Address (City, State &amp; Zip Code)

FAX Number

( )

**To be completed by Employer**

Hire Date

Occupation

Regular Scheduled Workweek

(Month, Day, Year)

Hours per week

Current work status (check one):  Active  Retired  Part-time  Full-time**Claim Information**

Were there any changes to the insured's job responsibilities due to the disabling condition before the insured became totally disabled? (Please check one.)  Yes  No If "Yes, what were the changes and when were they made?

What was the insured's permanent job on the last day of work?

How long has the insured been at this job?

Last day actually worked

Is the insured's condition work related?  Yes  No

(Month, Day, Year)

Date insured is expected/did return to work

Full Duty

Light duty

 Yes  No Yes  No

(Month, Day, Year)

**Signature**

Employer Signature: (If self-employed, insured must sign)

Date

( )

Telephone Number:

( )

FAX Number:

# APPLICATION FOR DISABILITY INCOME BENEFITS



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

**For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Oregon, Virginia and Puerto Rico:** A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

**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 New Jersey, Arkansas, and New Mexico:** 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 an insurance policy is subject to criminal and civil penalties.

**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 thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

**For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

**FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: "ANY PERSON WHO KNOWINGLY PRESENTS A 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 Louisiana:** 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 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 Puerto Rico:** Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**For residents of Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signature \_\_\_\_\_ Date \_\_\_\_\_

HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY  
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION



Name of Claimant \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

**TO:** Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies who has provided payment, treatment or services to me or on my behalf within the last 10 years,

Any past or present employer;

Any group insurance policyholder, insurance contract holder, insurance company or reinsurance company, benefit plan administrator, claims administrator that has provided payment, treatment or services to me or on my behalf within the last 10 years and Insurance Services Office, Inc.,

I have filed a claim for insurance coverage under a group life, accidental death and dismemberment and/or disability income policy issued by Hartford Fire Insurance Company, Hartford Life Insurance Company and/or Hartford Life and Accident Insurance Company. This Authorization is intended to comply with the requirements of §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. However, by signing this Authorization, I understand that Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company and their affiliates, employees, representatives and agents (collectively "Hartford") are not subject to the requirements of HIPAA. Hartford will use information received in accordance with this Authorization for the purpose of evaluating and administering claims for group life, accidental death and dismemberment and/or disability income benefits.

By signing this Authorization, I authorize you to release and disclose to Hartford, a complete copy of any and all health information, including but not limited to x-rays, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, toxicology/drug reports, autopsy reports and treatment notes (collectively, "Health Information"). For purposes of this Authorization, Health Information specifically includes confidential information regarding HIV/AIDS; sexually transmitted diseases and communicable diseases, alcohol or drug use, and treatment of mental illness, but excludes psychotherapy notes as defined by HIPAA.

By signing this Authorization, I acknowledge and agree that any agreements I have made to restrict disclosure of my Health Information do apply to this Authorization and I authorize any person or entity identified above to release and disclose my complete medical file with out restriction.

By signing this Authorization, I acknowledge that I understand the following:

- That any 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 knowledge of any person or entity authorized to disclose the Health Information. Note that Hartford will only use Health Information obtained under this Authorization for the purpose of evaluating and administering claims for group life, accidental death and dismemberment and/or disability income benefits, including obtaining reinsurance and conducting legal and business activities that relate to such claims. Hartford will only disclose Health Information obtained under this Authorization in accordance with its Corporate Privacy Policy.
- That my claim for benefits may be delayed and/or denied if Hartford is unable to obtain Health Information necessary to properly assess my claim because I do not properly sign, date, and deliver this authorization or any person subject to HIPAA that receives it does not comply with it.
- That, if necessary, Hartford will send this authorization to persons or entities authorized to release Health Information about me. I have a right, at any time, to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will not be effective to the extent that action has been taken in reliance upon this Authorization or Hartford otherwise has the right to contest the policy or claim under the policy.
- That this Authorization will expire two (2) years from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original and I am entitled to a signed copy of this

Signature of Claimant or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Description of Personal Representative's Authority or Relation to Insured (Required if signed by personal representative)



To be completed by the Insured

Name of Patient: Social Security Number: Date of Birth:
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.
Date:

To be completed by the Attending Physician

(The patient is responsible for the completion of this form without expense to the Company.)

DIAGNOSIS

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
Primary diagnosis: ICD-9 Code:
Secondary diagnosis(es): ICD-9 Code(s):
Subjective symptoms:
Test Results (list all results, or enclose test):
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? Date of next office visit:
Has patient been referred to any other physician? Yes No If "Yes," Date(s)
Name and address: Specialty:
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," Date(s) admitted: Date(s) discharged:
Name and address of hospital(s):
Progress (Please check one.): Recovered Improved Unchanged Retrogressed

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)?

- Inadequate information to make assessment.
- Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
- Moderate impairment in occupational functioning. Limited in performing some occupational duties.
- Major impairment in several areas -- work, family relations. Avoidant behavior, neglects family, is unable to work.
- Inability to function in almost all areas.

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

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

Attending Physician's Name: \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

License Number: \_\_\_\_\_ FAX Number: ( ) \_\_\_\_\_

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

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

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