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

INSTRUCTION PAGE

Claim form for Group Life Insurance Waiver of Premium for covered employees who have become disabled and unable to work.

Why apply for Group Life Waiver of Premium?

If a covered employee becomes 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.

** Note: **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.**

EMPLOYER'S RESPONSIBILITY - SECTION 1

1. Detach and complete the Employer Section, sign and date. Without this information, the claim cannot continue.
2. If any portion of the Group Life coverage was elected, please attach a copy of the enrollment history for all benefit elections.
3. Attach a copy of the most recent Beneficiary Designation Form.
4. Give the remaining sections of the form, including the instruction sheet, to your employee. Ask him/her to complete the Employee Sections and return the claim form to The Hartford. (Your employee should detach the *Attending Physician's Statement - Initial Report* [Attending Physician Statement], pages 1 and 2, and forward to his/her physician for completion).
5. SUBMIT THE EMPLOYER'S STATEMENT AND ATTACHMENTS DIRECTLY TO THE HARTFORD BEFORE THE CLAIM SUBMISSION PERIOD* SPECIFIED UNDER THE POLICY.

**** Please verify if the employee qualifies for any other group benefits through The Hartford and submit a claim accordingly.**

EMPLOYEE'S RESPONSIBILITY - SECTION 2

1. Fully complete Employee Section - pages 1 and 2.
2. Read, sign and date Important Notice and Claim Certification, Employee Section - page 3.
3. Read, complete, sign and date the Authorization at the bottom, Employee Section 2 - page 4.
4. Remove the Attending Physician's Statement - Initial Report - pages 1 and 2; and:
   a) Complete the Employee information at the top of the Attending Physician's Statement - Initial Report.
   b) Provide the Attending Physician's Statement - Initial Report, to the physician certifying your disability. Ask your physician to complete the form and return it within 10 days to The Hartford. Be advised that you are responsible for any fees charged by your physician for completion of this form.
5. TO QUALIFY FOR BENEFITS SUBMIT THE FOLLOWING BEFORE THE SUBMISSION PERIOD* SPECIFIED UNDER YOUR GROUP PLAN:
   a) Completed Employee Sections and all attachments. Make a copy to keep with your records;
   b) The Attending Physician's Statement - Initial Report, which should be sent separately by your physician;
   c) The Employer section, which should be sent separately.
6. Please follow up to make sure that this claim form, all attachments, and the *Attending Physician's Statement - Initial Report*, are received by The Hartford within the submission period* specified under your Group Life plan.

SEND THE CLAIM FORM TO:
THE HARTFORD
P.O. BOX 14296
Lexington, KY 40512-4296

FAX TO:
(877) 467-3037
E-MAIL TO:
gbclaimcspw@thehartford.com

For questions about how to complete this form call The Hartford Toll-free at:
1-888-563-1124

**** Please review your plan booklet to verify the submission period applicable to you.**

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

EMPLOYER SECTION 1

This is a time-sensitive document, please review the plan booklet to verify the submission period applicable.

***Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly.**

A. INFORMATION ABOUT YOUR COMPANY

Company Name

Address (Street, City, State, Zip Code)

Name and address of division where employee works, if different from above:

Group Policy Number	Telephone Number ( )	Fax Number ( )	E-Mail address

B. INFORMATION ABOUT YOUR EMPLOYEE

Employee's Name	Social Security Number	Date of Birth

Address (Street, City, State, Zip Code) | Telephone Number ( )

Date hired: ☐ Full time ☐ Part time | Date Group Life Insurance became effective: ________ | Last day worked: ________ | Premiums paid to date? ☐ Yes ☐ No

Employee Division | ☐ Exempt ☐ Non-exempt ☐ Salaried ☐ Hourly

Group Life: Insurance coverage amount: **Basic Life $** ________ | **Supplemental Life $** ________ (Attach enrollment forms & beneficiary form.)

Permanent Total Disability Benefits:

Amount of **Basic Life** Insurance $________ Amount of **Supplemental Life** Insurance $ ________

Amount of Permanent Total Disability requested $ ________ | Number of hours scheduled to work weekly ________

Rate of Annual Basic Earnings on date last worked: $ ________ per ☐ Hour ☐ Week ☐ Month ☐ Year **(Attach W-2, if applicable)**

Do earnings include commissions, bonuses or overtime? ☐ Yes ☐ No If "Yes," please specify:

Are employee's eligible dependents covered by Waiver of Premium or Disability Extension benefits? ☐ Yes ☐ No
If "Yes", please provide amounts of Group Life coverage and enrollment history:

Spouse's Name:________ Date of Birth: ________ Coverage Amount: ________
Child's Name: ________ Date of Birth: ________ Coverage Amount: ________
Child's Name: ________ Date of Birth: ________ Coverage Amount: ________

Has employment been terminated/retired? ☐ Yes ☐ No If "Yes," date:________

Was an application for conversion offered? ☐ Yes ☐ No

C. INFORMATION ABOUT THE DISABILITY

Before the employee became totally disabled, were any changes made to the employee's job responsibilities because of the disabling condition? ☐ Yes ☐ No. If "Yes," what were the changes and when were they made?________

What was the employee's permanent job or occupation title on his or her last day at work? ________

How long had the employee been in this job? ________ | Full time? ☐ Yes ☐ No

Date employee is expected to, or did return to work: ________ | Why did employee stop working?________

Is the cause of employee's condition work related? ☐ Yes ☐ No

Is your employee receiving income from other sources? e.g.: ☐ Short Term Disability ☐ Long Term Disability
☐ Workers' Compensation ☐ Social Security **(If applicable, provide name and address of insurance carrier:)**

D. REQUIRED ATTACHMENTS AND SIGNATURE

For Voluntary Group Life Insurance coverage, attach a copy of the enrollment form history, and/or copies of the Electronic Benefits (screen prints). I hereby certify that the information provided in the Employer's Section is true and complete to the records of the Employer, I agree that this information is subject to audit by Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or Hartford Life Group Insurance Company and/or its representatives.

________ ________
Name *(Please print or type)* Title

________ ________ ( ) ________
Signature of Employer Representative Date Telephone Number

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

EMPLOYEE SECTION 2

This is a time-sensitive document

***Please review your plan booklet to verify the submission period applicable to you.**

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: ______________

If your Policy contains a Permanent and Total Disability provision and you are eligible and would like to apply, please complete below:

Amount of Permanent Total Disability (PTD) requested*: $ ______________

***Note**: The amount requested may not exceed the percentage of the Employee/Insured's Life Insurance Amount set forth in the policy and is subject to the minimum and maximum amounts contained in the Policy. **As a result of electing the Permanent Total Disability benefit, the total face amount of your group life insurance coverage will be reduced by the amount of the Permanent Total Disability benefit.**

At the time of 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 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 Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon Pennsylvania, Puerto Rico, Tennessee 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 Arizona: For your protection, Arizona law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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 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 nformation 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.

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 the state law.

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 ______________

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To: Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, 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, and to communicate telephonically or electronically with The Hartford's representatives about, any and all of the following personal, private, 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 medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all 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 by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and/or leave request and/or request for accommodation. 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 restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); 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, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any 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, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) 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, respond to regulatory complaints, 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 Authorized Representative	Date (Valid for 2 years)	Relationship to Insured *(if signed by Authorized Representative)*

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Please fax the completed form to:
Fax Number: 877-467-3037
The Hartford
P.O. Box 14296
Lexington, KY 40512-4296

ATTENDING PHYSICIAN'S STATEMENT - INITIAL REPORT

To be completed by the Employee

Patient Name:	Date of Birth:	Insured ID Number:

Patient Address: (Street, City, State & Zip Code)

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

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

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

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Medical Conditions Impacting Activity

Primary condition: ____________________ ICD-9 Code: ☐ ________ ICD- 10 Code: ☐ ________

Secondary condition(s): ____________________ ICD-9 Code: ☐ ________ ICD-10 Code(s): ☐ ________

Subjective symptoms: ____________________

Objective Physical Findings (Please include office notes for date(s): ____________ to ____________

Pertinent Test Results (list all results or attach test results):

Test: ____________________ Date: __________ Results: ____________________

Test: ____________________ Date: __________ Results: ____________________

Condition(s) Specific Medications, Dosage and Frequency:

Treatments

Date your patient reported stopping work: __________ Date of disability: __________ Expected Return to Work Date: __________

Date you first treated this patient: __________ Date you first treated this patient for this condition: __________

Date of reported onset of this condition: __________ Date of most recent treatment: __________

How often has patient been seen/treated for this condition? __________ Date of next office visit: __________

Current Treatment Plan: ____________________

Has surgery been performed? ☐ Yes ☐ No Is surgery planned? ☐ 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 of Hospital: ____________________ Telephone Number of Hospital: ( ) __________

Has patient been referred to any other physician? ☐ Yes ☐ No If "Yes," Date(s) of Referral: __________ __________

Other Physician Name: ____________________ Phone Number: ( ) __________ Specialty: __________

Other Physician Name ____________________ Phone Number: ( ) __________ Specialty: __________

The Hartford® is underwriting companies Hartford Life and Accident Insurance Company and Hartford Life Insurance Company.
The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Patient Name: Date of Birth: Insured ID Number:

Complete this section to the best of your ability. Õ^}^¦æ|ã^åÁcomments such as‰}æà|^Á[Á¸[¦\+Á[æÂ&^|æÂ[˘¦Á|æã^}c|Á&ã æàã|ãc benefits.

Based on your medical findings and opinion, address the full range of restrictions/limitations at the time patient stopped working, reduced their work schedule or initially visited your office for this condition, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: ________________

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent circle time for each section below: Hours at one time	If intermittent circle time for each section below: Total hours/8 hours
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

____

____

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	☐	☐	☐	☐	
Kneel/crouch	☐	☐	☐	☐	
Climb	☐	☐	☐	☐	
Balance	☐	☐	☐	☐	
Drive	☐	☐	☐	☐	
Lift - Indicate weight in pounds		_______ lbs.	______ lbs.	______ lbs.	.
Other Restrictions (if any) ____________	☐	☐	☐	☐	
Hand Dominance: ☐ Right ☐ Left					
Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral					
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: ______________

Current Status (Please check one): ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Additional Comments (If Necessary): ____

____

Does the patient have a psychiatric / cognitive impairment? ☐ Yes ☐ No If "Yes", please describe the extent of the impairment and its etiology: ____

____

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

Provider's Name: (please print or type)		EIN Number:	License Number:
Telephone Number: ( )	Fax Number: ( )	Degree:	Specialty:

Street Address (Street, City, State & Zip Code):

Office Contact and Telephone Number:

____ ____________________

Provider's Signature: Date signed: