



**HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford Life Group Insurance Company**

**APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS
for the State of Minnesota**

- Section I Employer's Statement** - to be completed by employer's authorized representative.
- 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 or another document that verifies the employee's date of birth.
- Section III Informed Consent** - to be signed by the employee.
- Section IV Authorization to Obtain Information** -to be signed by the employee.
- Section V Attending Medical Provider's Statement** - to be completed by the medical provider who is treating the employee.

EMPLOYEE:

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO:

**Minneapolis Disability
The Hartford
P.O. Box 14305
Lexington, KY 40512-4305**

**Phone: 1.800.752.9713
FAX: 1.877.454.7217**

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY



Section I
Employer's Statement

To be Completed by the Employer

This claim is for (Employee's Name) Social Security Number Date of Birth

Employee's Address (Street, City, State, Zip)

A. Information About the Employer

Employer: State of Minnesota
Agency or IBU name:
Address (Street, City, State, Zip)
Name and address where employee works (if different from above)
Group Policy Number GLT-23458
Telephone Number
Fax Number

B. Information About the Employee

Has the employee separated from employment? Yes No If "Yes," date:
What was the employee's regularly scheduled work week?
Average Number of Hours per Week Scheduled workdays M - F ? Yes No Other
Employee's weekly/hourly rate of pay \$

C. Information About the Claim

What was the employee's job title on his or her last day at work? How long had the employee been in this job?

Last day employee actually worked (Please note: An employee's last day worked is the actual day last worked, not the date through which earnings or sick pay were paid.)

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

Why did employee stop working (if known)?

Has a claim been filed with Workers' Compensation for this condition? Yes No Unknown

Has the Workers' Compensation claim been approved? Yes No Unknown

Date employee is expected/did return to work Unknown

Will the employee return to a reduced work schedule? Yes No Unknown

D. 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.

(or attach the Essential Job Functions, if available.)

Frequency Of Occurance

Activity	N/A	Occasionally	Frequently	Continuously
Standing	<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"/>
Sitting	<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"/>
Stooping	<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"/>
Crouching	<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"/>
Reaching/working overhead	<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"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Description	Frequency	Weight
<input type="checkbox"/> Pushing	_____	_____	_____ lbs.
<input type="checkbox"/> Pulling	_____	_____	_____ lbs.
<input type="checkbox"/> Lifting	_____	_____	_____ lbs.
<input type="checkbox"/> 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.

_____	_____ %
_____	_____ %
_____	_____ %

E. Required Attachments and Signature

Please attach a copy of the employee's job description, if available.

Name (Please print or type) _____
Date

Signature _____
Title

**Employee's Statement
APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS
HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**



Section II

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	Social Security Number
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Address (Street)	City	State/Province	Zip
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Telephone Number
()

Date of Birth (Month, Day, Year)	Height	Weight	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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Your employer (include agency/location)	Occupation/Job Title
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When your disability began, did you have more than one employer (includes self-employment)? Yes No. If "Yes," please provide the name, address and phone number of that employer. Indicate the dates when you worked (or were self-employed).

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

High School: 1 2 3 4
 College: 1 2 3 4
 Trade School: _____ Masters _____ Ph.D. _____
 Current Occupational Licenses: _____

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 (Please note: Eligibility of family members for Social Security Benefits may affect your disability benefit from Hartford.)

Spouse's Name (Last, first)

Spouse's Social Security Number	Date of Birth (Month, Day, Year)	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you have any children under Age 19? Yes No
 If "Yes," name and date of birth of each child

Do you have any children with disabilities (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 Medical Provider?

Name of Medical Provider _____

(Month Day Year)

Address 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 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 for compensation? Yes No
If "Yes," please indicate dates worked, name of employer, & amount earned and amount earned.

If you have not returned to work, do you expect to?
 Yes No Unknown

Do you expect to work reduced hours? Yes No Unknown

What date do you expect to return? _____

E. Information About Medical Provider and Hospitals

First medical attention for the current disability was given by (complete below)

Medical Provider's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates seen to

List all Medical Providers and Hospitals you have seen for this condition (attach separate sheet, if needed)

Medical Provider's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates seen to

Hospital	Dates of Confinement to
Address (Street, City, State, Zip)	

Have you consulted any other Medical Provider or been hospitalized in the past three years? Yes No
If "Yes," complete the following concerning your past treatment (attach separate sheet, if needed)

Medical Provider's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates seen to

Hospital	Dates of Confinement to
Address (Street, City, State, Zip)	

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

F. Other Income *(Please note: Since the benefit rate is affected by the amount of other income benefits you receive or are entitled to receive, it is important that you complete this section accurately.)*

Check the other income benefits you have received/are receiving, or are eligible to receive during your disability (complete the information requested).

Source of Income	Amount(week /month)	Date Claim was filed	Date Payments began	Date Payments ended
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

Federal law requires us to withhold federal income tax from your check **if you request us to do so**. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (*minimum is \$88.00 per month*): \$ _____ .00.

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

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford 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, Colorado, Florida, Kentucky, Maine, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation 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 are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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

Signature

Date

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



APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

Section III

Informed Consent to Release Private Data - to be completed by employee

I, _____, authorize a representative of the Human Resources Office of _____ to release private data about me to _____
(applicable State Agency)

Hartford Life and Accident Insurance Company (hereinafter called The Hartford). The following private data covered by this release is requested in the Employer's Statement section of this disability claim form:

- √ Your social security number
- √ Your date of birth
- √ Your home address
- √ Reason why you were unable to continue working
- √ Whether a Workers' Compensation claim has been filed for the same condition, and whether the claim has been approved

I understand that The Hartford and their representatives will use this information to process my short and/or long term disability claim(s).

I understand that the data listed above is data that is classified as private data on me under Minnesota Statute 13.43 (Minnesota Government Data Practices Act) or Rules of Public Access to Records of the Judicial Branch, and under Minnesota Statutes 176.138 and 176.231 (governing Workers' Compensation data). I understand that by signing this Informed Consent Form, I am authorizing the Human Resources Office to release the data listed above to The Hartford and their representatives for the purpose of processing my claim. I understand that without my informed consent, my employer cannot release this data to The Hartford. However, I further understand that my refusal to authorize release of this data to The Hartford may hamper The Hartford's ability to process my claim.

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

This consent expires upon my employer's release of the above stated data or after one year, whichever comes first. However, if the above-described purpose is not fulfilled after one year, I may renew this consent.

I understand that I will be notified by my employer if any additional private data on me is requested by The Hartford, and I further understand that no additional private data may be released by my employer without my authorization.

I am giving this consent freely and voluntarily and I understand the consequences of my giving this consent.

Dated: _____ Signed: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION



Section IV

To: Any health care provider , employer, benefit plan, insurer , financial institution, consumer reporting agency , educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to The Hartford¹ a complete copy of any and all of the following personal or privileged information, records or documents relative to:

Insured's Name (*Please print*)

Date of Birth

Last 5 Digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, and payment records; academic transcripts; and information concerning Social Security benefits, including, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits under my employer's benefit plan. 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 ALSO UNDERSTAND that once My Information has been disclosed to The Hartford, as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. I authorize The Hartford to use or disclose My Information (i) to my employer for ; a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; e) matters relating to its workers' compensation arrangements; or f) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related my claim; vi) to my employer's workers' compensation insurance carrier or administrator; (vii) as may be lawfully required; or (viii) as may be necessary to prevent or detect perpetration of a fraud.

I 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 or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian

Date

Relationship to Insured (*if signed by Guardian*)

¹ The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and its administrative services company Hartford-Comprehensive Employee Benefit Service Company, and any of their parents, affiliates, subsidiaries and/or third-party contractors. Also as used herein, The Hartford provides insurance or claim administration services to my employer's employee welfare benefit plan(s).

Section V
ATTENDING MEDICAL PROVIDER'S STATEMENT OF DISABILITY

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS



To be completed by the Employee

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.

Signed (Patient) _____ Date: _____

To be completed by the Attending Medical Provider (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: _____ ICD-9 Code: _____

Secondary diagnosis(es): _____ ICD-9 Code(s): _____

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? _____ Date of next office visit: _____

Has patient been referred to any other Medical Provider? Yes No If "Yes" Dates(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

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

ATTENDING MEDICAL PROVIDER'S 'S STATEMENT OF DISABILITY (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)?

- Inadequate information to make assessment.
 Essentially good functioning in all areas. Occupationally and socially effective.
 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 Medical Provider's Name: _____ Telephone Number: () _____
(Please print or type.)

License Number: _____ Fax Number: () _____

SS# or E.I.N.#: _____ Degree: _____ Specialty: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Signature: _____ Date signed: _____