HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

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

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

Section Ic. **Information for Group Life Premium Waiver Benefits -** to be completed by the employer's authorized representative if the employer also has a Group Life Insurance policy with The Hartford that includes a Premium Waiver benefit. Be sure to provide any necessary attachments (see Section K)

Section II **Employee's Statement -** to be completed by the employee who is applying for Long Term Disability benefits. Please attach a copy of the employee's driver's license.

Section III **Authorization to Obtain Information -** to be signed by the employee.

Section IV **Attending Physician's Statement -** to be completed by the physician who is treating the employee.

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

LC-4571-15 Rev 09/02 (Printed in U.S.A.)

THE HARTFORD

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

Section II
Employee's Statement

To Be Completed by the Employee (**BE SURE TO ANSWER ALL QUESTIONS — FAILURE TO DO SO MAY DELAY YOUR CLAIM**)

A. Information about you

Last name	First	Middle Initial	Social Security Number

Address *(Street)* City State/Province Zip

Telephone Number

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

Your employer *(include division, if applicable)* Occupation

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 *(Circle one)*

High School: 1 2 3 4 5 6 7 8 9 10 11 12
College: 1 2 3 4 Masters _____ Ph.D. _____

Trade School: _____

Briefly describe your past work experience for the last 20 years *(Begin with your most recent job.)*

	Job Title	Duties	Years Worked
(a)			
(b)			
(c)			
(d)			

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work? ☐ Yes ☐ No

Have you contacted your State Department of Vocational Rehabilitation? ☐ Yes ☐ No
If "Yes," please include the name, address and telephone number of your counselor.

B. Information About your Family *(required to determine your eligibility for Social Security Benefits)*

Spouse's Name *(Last, first)*

Spouse's Social Security Number	Date of Birth *(Month, Day, Year)*	Is your spouse employed?	Retired?
		☐ Yes ☐ No	☐ Yes ☐ No

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

1a. For illness, answer the following questions:

What were your first symptoms?

When did you first notice them? Have you had this illness before? ☐ Yes ☐ No If so, when?

C. Information About the Condition Causing Your Disability *(cont'd...)*

1b. Next to any Activity of Daily Living (ADL), please place the number shown next to the statement that most accurately reflects your ability/inability to perform each: 1 = I can perform this activity independently; 2 = I can perform this activity with the use of equipment or adaptive devices; 3 = I cannot perform this activity.

( ) Bathe *(tub, shower, or sponge)*
( ) Dress
( ) Toilet
( ) Transfer from Bed to Chair
( ) Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene.
( ) Feed yourself with food that has been prepared and made available to you.

If you indicated **(3)** for any of the above activities, please describe the impairment and restrictions to your functionality that preclude you from performing the activity.

Have you suffered a severe Cognitive Impairment that renders you unable to perform common tasks, such as using the phone, money management, or medication management? ☐ Yes ☐ No If "Yes," describe:

2. For an injury, answer the following questions:

When, where and how did the injury occur?

3. For Illness, Injury or Pregnancy, answer the following questions:

Date you were first treated by a physician? _____ (Month Day Year)

Name of Physician _____

Address of Physician _____

Before you stopped working, did your condition require you to change your job, or the way you did your job? ☐ Yes ☐ No If "Yes," explain:

What aspect of your condition made you unable to work?

Is your condition related to your occupation? ☐ Yes ☐ No If "Yes," explain:

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

D. Information About the Disability

Last day you worked before the disability _____ (Month Day Year)

Did you work a full day? ☐ Yes ☐ No If "No," explain:

Date you were first unable to work _____ (Month Day Year)

Since that date, have you done any work? ☐ Yes ☐ No If "Yes," please indicate dates worked, name of employer, and amount earned.

If you have not returned to work, do you expect to?
☐ Yes Part time *(date)* _____ Full time *(date)* _____
☐ No

E. Information About Physicians and Hospitals

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

Doctor's Name	Telephone FAX	Specialty
Address *(Street, CIty, State, Zip)*		Dates seen **to**

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

Doctor's Name	Telephone FAX	Specialty
Address *(Street, City, State, Zip)*		Dates seen **to**

Hospital

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

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

Doctor's Name	Telephone FAX	Specialty
Address *(Street, City, State, Zip)*		Dates Seen **to**

Hospital

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

F. Other Income

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

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 $87.00 per month)*: $ _____.00.

H. Signature

With the exception of any source(s) of income reported above in Section F of this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my Hartford Disability Income. 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 benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, Oregon, and Virginia: 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, New Mexico, and Louisiana: Any person who knowingly files a statement of claim containing anyfalse 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 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 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 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.

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

X _____ **X** _____

SIGNATURE OF THE EMPLOYEE ***DATE***

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

Authorization to Obtain and Release Information

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies;

any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or

any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize you to release and send to: (i) Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and any affiliate of one or more of these three companies, known collectively as The Hartford; or (ii) The Hartford's representatives, a complete copy of any and all of the following information, records or documents relative to

_____ Insured's Name *(Please print.)*

_____ (Date of Birth) _____ (Social Security Number)

1. Any and all medical information, including x-ray films, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits.

2. Work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, and and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including, but not limited to, credit reports and credit applications; other financial information, e.g., Pension Benefits, bank records; business transactions of any kind or description, including billing, invoices or payment records of any kind; and academic transcripts.

3. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record.

I understand that the information obtained by use of the Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by The Hartford to any person or organization EXCEPT to reinsuring companies or their representatives, The Index System, physicians who have treated me, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required, or as I may further authorize, or as may be necessary to prevent or to detect the perpetration of a fraud.

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

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

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

_____ Signature of Insured or Guardian

_____ Relationship to Insured *(if signed by Guardian)*

_____ Date

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

To be completed by the Employee

Name of patient _____ Social Security Number _____ D.O.B _____

Address of patient _____
Street *City* *State or Province* *Zip Code or Postal Code*

Employer's name *(and division, if applicable)* _____

I hereby authorize release of information on this form by the below named physician for the purpose of claim processing. SIgned *(Patient)* _____ Date: _____

To be completed by the Attending Physician *(The patient is responsible for the completion of this form without expense to the Company.)*

Patient's condition is the result of: ☐ Illness ☐ Injury ☐ Pregnancy Height _____ Weight _____

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

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

DIAGNOSIS

Primary diagnosis: _____ 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 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

ATTENDING PHYSICIAN'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 Physician's Name: _____ Telephone # _____

(Please print or type.)

License No. _____ FAX # _____

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

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

Signature: _____ Date signed: _____

Hartford Life Insurance Company
Hartford Life and Accident Insurance Company

Sample Completed Long Term Disability Claim Form

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HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

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LC-4571-13 (Printed in U.S.A.)

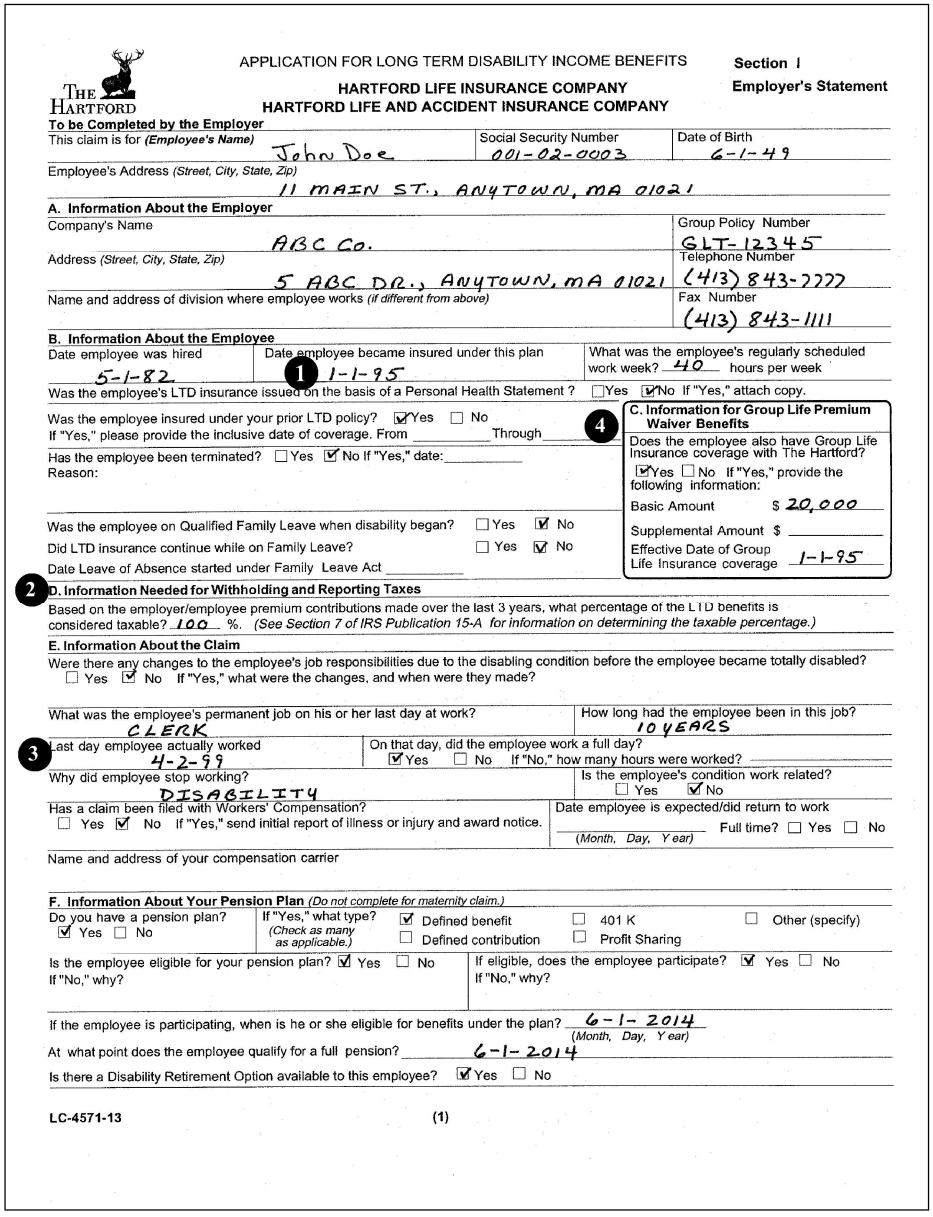
Employer's Statement

1. Date employee became insured under this plan? This is usually the day following completion of the Eligibility Waiting Period for the group policy. If the employee was a late enrollee, however, the effective date is the date the employee's Personal Health Statement was approved by The Hartford.

2. Information needed for withholding and reporting taxes. This information is important because it determines the amount of taxable wages and/or benefits that should be reported for the employee. The portion of the benefit funded by you is taxable.

3. Last day employee actually worked? This is the *actual* last day the employee worked, not the date through which earnings or sick pay were continued.

4. Complete this section if employee has Hartford Life Insurance.



THE HARTFORD

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS — Section I
HARTFORD LIFE INSURANCE COMPANY — Employer's Statement
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

To be Completed by the Employer

This claim is for *(Employee's Name)*: John Doe | Social Security Number: 001-02-0003 | Date of Birth: 6-1-49

Employee's Address *(Street, City, State, Zip)*: 11 MAIN ST., ANYTOWN, MA 01021

A. Information About the Employer

Company's Name: ABC Co. | Group Policy Number: GLT-12345

Address *(Street, City, State, Zip)*: 5 ABC DR., ANYTOWN, MA 01021 | Telephone Number: (413) 843-7777

Name and address of division where employee works *(if different from above)* | Fax Number: (413) 843-1111

B. Information About the Employee

Date employee was hired: 5-1-82 | Date employee became insured under this plan: 1 1-1-95 | What was the employee's regularly scheduled work week? 40 hours per week

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

Was the employee insured under your prior LTD policy? ☑ Yes ☐ No
If "Yes," please provide the inclusive date of coverage. From _____ Through _____

Has the employee been terminated? ☐ Yes ☑ No If "Yes," date: _____
Reason:

Was the employee on Qualified Family Leave when disability began? ☐ Yes ☑ No

Did LTD insurance continue while on Family Leave? ☐ Yes ☑ No

Date Leave of Absence started under Family Leave Act _____

C. Information for Group Life Premium Waiver Benefits 4

Does the employee also have Group Life Insurance coverage with The Hartford?
☑ Yes ☐ No If "Yes," provide the following information:

Basic Amount $ 20,000

Supplemental Amount $ _____

Effective Date of Group Life Insurance coverage 1-1-95

2 **D. Information Needed for Withholding and Reporting Taxes**

Based on the employer/employee premium contributions made over the last 3 years, what percentage of the LTD benefits is considered taxable? 100 %. *(See Section 7 of IRS Publication 15-A for information on determining the taxable percentage.)*

E. Information About the Claim

Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became totally disabled?
☐ Yes ☑ No If "Yes," what were the changes, and when were they made?

What was the employee's permanent job on his or her last day at work? CLERK | How long had the employee been in this job? 10 YEARS

3 Last day employee actually worked: 4-2-99 | On that day, did the employee work a full day? ☑ Yes ☐ No If "No," how many hours were worked? _____

Why did employee stop working? DISABILITY | Is the employee's condition work related? ☐ Yes ☑ No

Has a claim been filed with Workers' Compensation? ☐ Yes ☑ No If "Yes," send initial report of illness or injury and award notice. | Date employee is expected/did return to work _____ (Month, Day, Year) Full time? ☐ Yes ☐ No

Name and address of your compensation carrier

F. Information About Your Pension Plan *(Do not complete for maternity claim.)*

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

Is the employee eligible for your pension plan? ☑ Yes ☐ No
If "No," why?

If eligible, does the employee participate? ☑ Yes ☐ No
If "No," why?

If the employee is participating, when is he or she eligible for benefits under the plan? 6-1-2014 (Month, Day, Year)

At what point does the employee qualify for a full pension? 6-1-2014

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

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Employer's Statement
(Continued)

5. Information about the employee's salary. This information should be based on the policy's specific definition of Basic Monthly Earnings. If you record earnings as an hourly rate, please be sure to include the number of hours worked in a regular week.

6. Please note the request in Section K.

G. Information About Your Rehire or Return-to-Work Policies

Does your company have a rehire or return-to-work policy for disabled employees? ☑ Yes ☐ No
What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?

5

I. Information About the Employee's Salary

Basic Salary or wage immediately prior to cessation of work because of disability (exclude bonuses, overtime, pay, etc.)
$ 2000 ☑ Monthly ☐ Weekly ☐ Annually ☐ Hourly # Hours/Week ____

Is this employee eligible for salary continuation?
☑ Yes ☐ No If "Yes," what is the weekly amount? $ 461.53 When do benefits begin? 4-3-99 End? 10-3-99

Will the employee file for Short Term or State Disability benefits?
☐ Yes ☑ No If "Yes," what is the weekly amount? $ ____ When do benefits begin? ____ End? ____

List any other sources of income to which the employee is entitled as a result of this disability:

I. 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.

	Frequency of Occurrence			
Activity	**N/A**	**Occasionally**	**Frequently**	**Continuously**
☑ Standing	☐	☑	☐	☐
☑ Walking	☐	☑	☐	☐
☑ Sitting	☐	☐	☑	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Reaching/working overhead	☐	☐	☐	☐
☑ Keyboard Use/Repetitive Hand Motion	☐	☐	☑	☐
☐ Climbing	☐	☐	☐	☐

Activity	Description	Frequency	Weight
☐ Pushing			____ lbs.
☐ Pulling			____ lbs.
☐ Lifting			____ lbs.
☐ 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.

KEYBOARD 75 %
____ %
____ %

J. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☑ No If "Yes," explain.

Is it possible to offer the employee assistance in doing the job ***(e.g., through the use of technology or personal assistance)***? ☐ Yes ☐ No If "Yes," explain.

6

K. Required Attachments and Signature

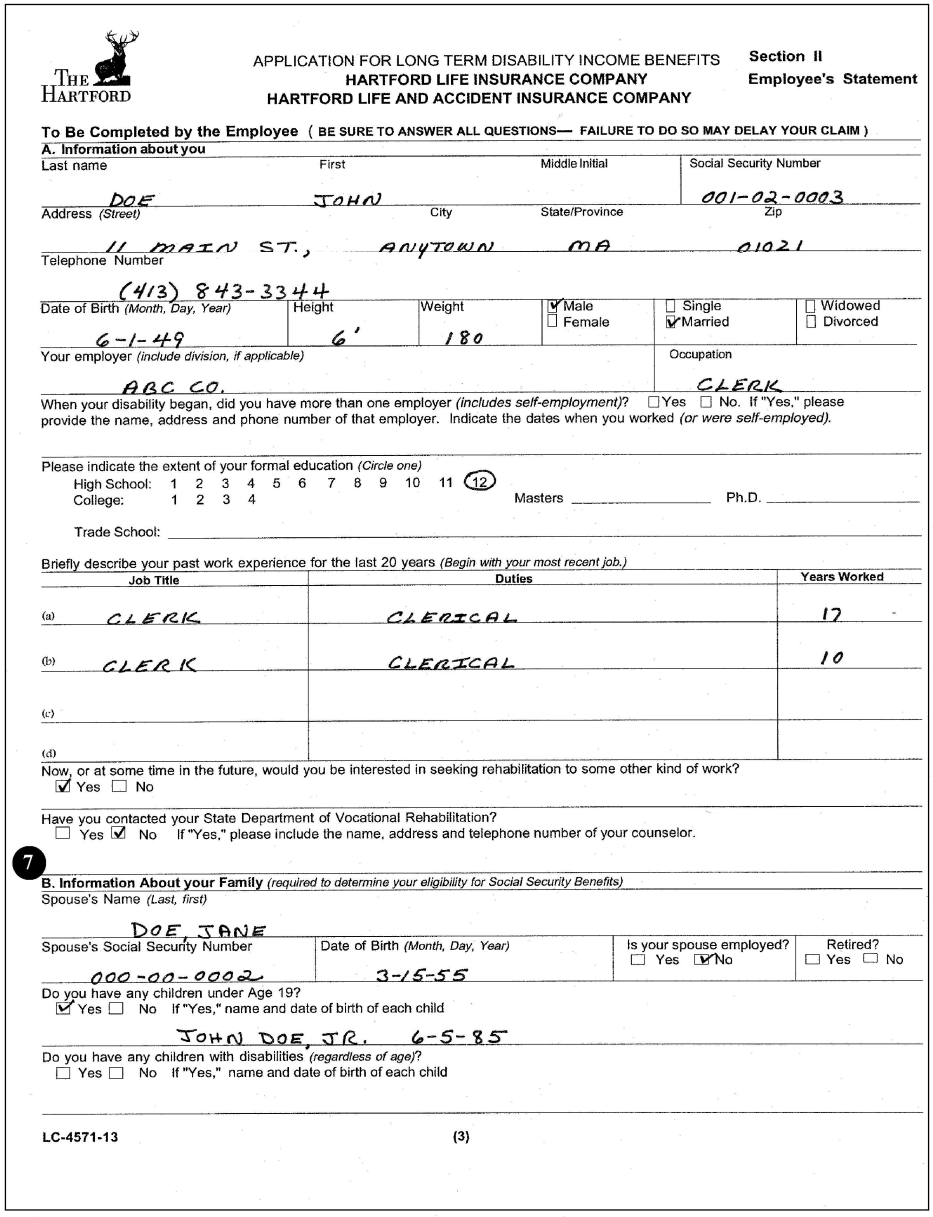
Please attach a copy of the employee's job description.
If the employee contributes to the premiums for LTD or Group Life Insurance coverage, attach a copy of the enrollment form and/or copies of the last two Flexible Benefits Election forms.
If salary is based on a W-2, K-1, 1099, or a similar document, attach a copy of the document.
If you have medical information from the employee's file relating to this disability, please attach copies.
If a Workers' Compensation claim is filed, send initial report of injury or illness and award notice.
Name of person completing this form *(if this claim is approved for disability benefits, the benefit check will be sent to the employee with a copy to you).*

RALPH SMITH (Name (Please print or type)) HR DIRECTOR (Title)
Ralph Smith (Signature) 5-20-99 (Date)

LC-4571-13 (2)

Employee's Statement

7. Information about your family. This information helps determine whether dependent Social Security benefits might be payable.



THE HARTFORD

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

Section II
Employee's Statement

To Be Completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS— FAILURE TO DO SO MAY DELAY YOUR CLAIM)

A. Information about you

Last name	First	Middle Initial	Social Security Number
DOE	JOHN		001-02-0003

Address (Street)	City	State/Province	Zip
11 MAIN ST.,	ANYTOWN	MA	01021

Telephone Number: (413) 843-3344

Date of Birth (Month, Day, Year)	Height	Weight	☑ Male ☐ Female	☐ Single ☑ Married	☐ Widowed ☐ Divorced
6-1-49	6'	180			

Your employer (include division, if applicable): ABC CO.
Occupation: CLERK

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 (Circle one)
High School: 1 2 3 4 5 6 7 8 9 10 11 (12)
College: 1 2 3 4
Masters _____ Ph.D. _____
Trade School: _____

Briefly describe your past work experience for the last 20 years (Begin with your most recent job.)

	Job Title	Duties	Years Worked
(a)	CLERK	CLERICAL	17
(b)	CLERK	CLERICAL	10
(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.

7

B. Information About your Family (required to determine your eligibility for Social Security Benefits)

Spouse's Name (Last, first): DOE, JANE

Spouse's Social Security Number	Date of Birth (Month, Day, Year)	Is your spouse employed? ☐ Yes ☑ No	Retired? ☐ Yes ☐ No
000-00-0002	3-15-55		

Do you have any children under Age 19?
☑ Yes ☐ No If "Yes," name and date of birth of each child
JOHN DOE, JR. 6-5-85

Do you have any children with disabilities (regardless of age)?
☐ Yes ☐ No If "Yes," name and date of birth of each child

LC-4571-13 (3)

Employee's Statement
(Continued)

C. Information About the Condition Causing Your Disability

1. For illness, answer the following questions:

What were your first symptoms?

BACK PAIN

When did you first notice them?

SIX MONTHS AGO

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

No

2. For an injury, answer the following questions:

When, where and how did the injury occur?

10/98 At Home Carrying a ladder

3. For Illness, Injury or Pregnancy, answer the following questions:

Date you were first treated by a physician? 2 (Month) 5 (Day) 99 (Year)

Name of Physician DR. RALPH JONES

Address of Physician 5 FIRST ST., ANYTOWN, MA 01021

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?

SITTING

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: 4 (Month) 2 (Day) 99 (Year)

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

Date you were first unable to work: 4 (Month) 3 (Day) 99 (Year)

Since that date, have you done any work? ☐ Yes ☑ No
If "Yes," please indicate dates worked, name of employer, and amount earned.

If you have not returned to work, do you expect to?
☐ Yes Part time (date) _____ Full time (date) _____
☐ No

E. Information About Physicians and Hospitals

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

Doctor's Name	Telephone FAX: ( )	Specialty
DR. RALPH JONES		ORTHOPEDICS
Address *(Street, City, State, Zip)*		Dates seen
5 FIRST ST., ANYTOWN, MA 01021		2-15-99 to PRESENT

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

Doctor's Name	Telephone FAX: ( )	Specialty
Address *(Street, City, State, Zip)*		Dates seen to

Hospital: UNIVERSITY HOSPITAL

Address *(Street, City, State, Zip)*	Dates of Confinement
15 FIRST ST., ANYTOWN, MA 01021	4-12-99 to 4-17-99

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

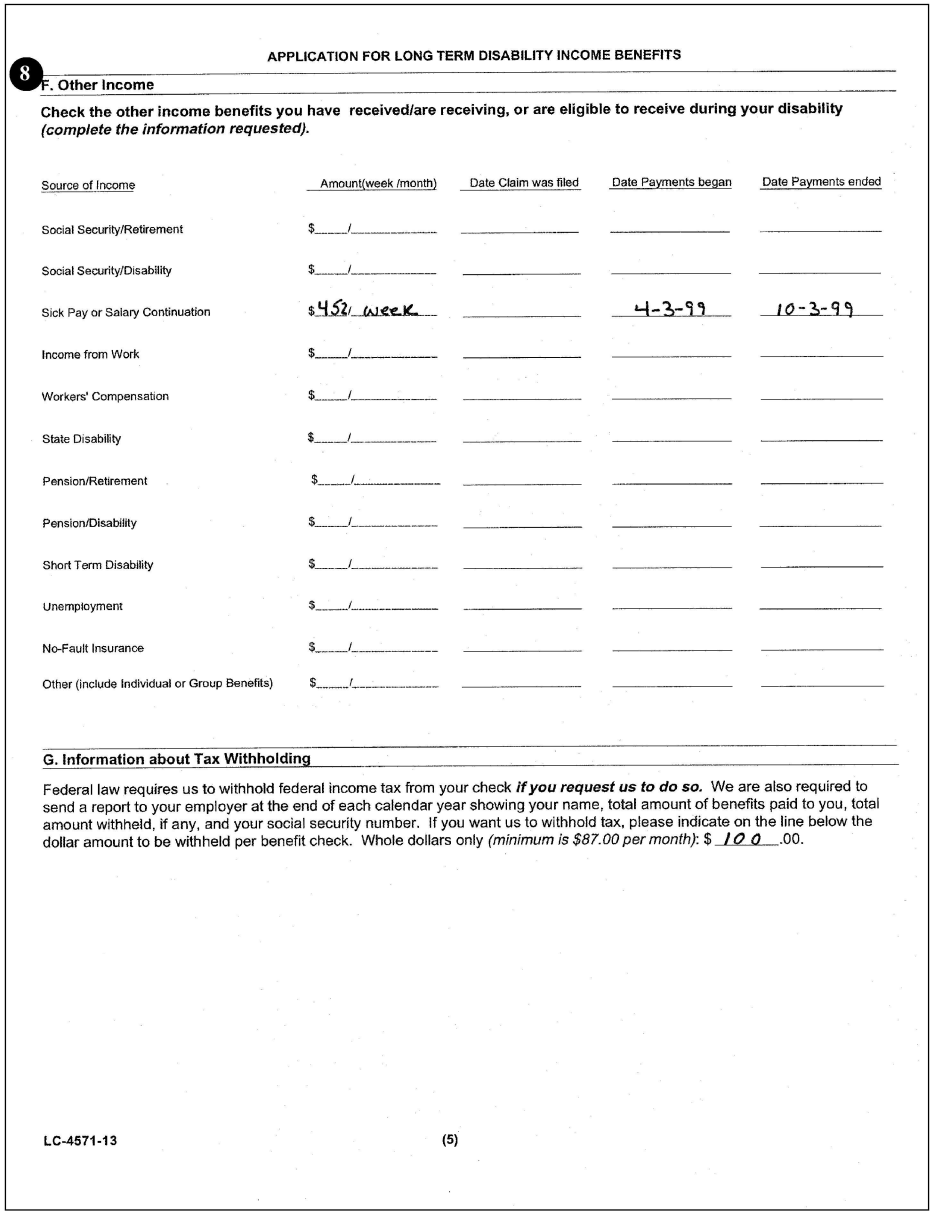
Doctor's Name	Telephone FAX: ( )	Specialty
Address *(Street, City, State, Zip)*		Dates seen to

Hospital

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

Employee's Statement
(Continued)

8. Other income Since the LTD benefit rate is affected by the amount of other income benefits you receive or are eligible to receive, it's important that you complete this section accurately.



APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

8 **F. Other Income**

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

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	$452/ week		4-3-99	10-3-99
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 $87.00 per month)*: $ 100 .00.

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Employee's Statement
(Continued)

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

H. Signature

With the exception of any source(s) of income reported above in Section F of this form, I certify by my signature that I have not and am not eligible to receive any source of income, except for my Hartford Disability Income. 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 benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, Oregon, and Virginia: 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, New Mexico, and Louisiana: 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 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 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 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.

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

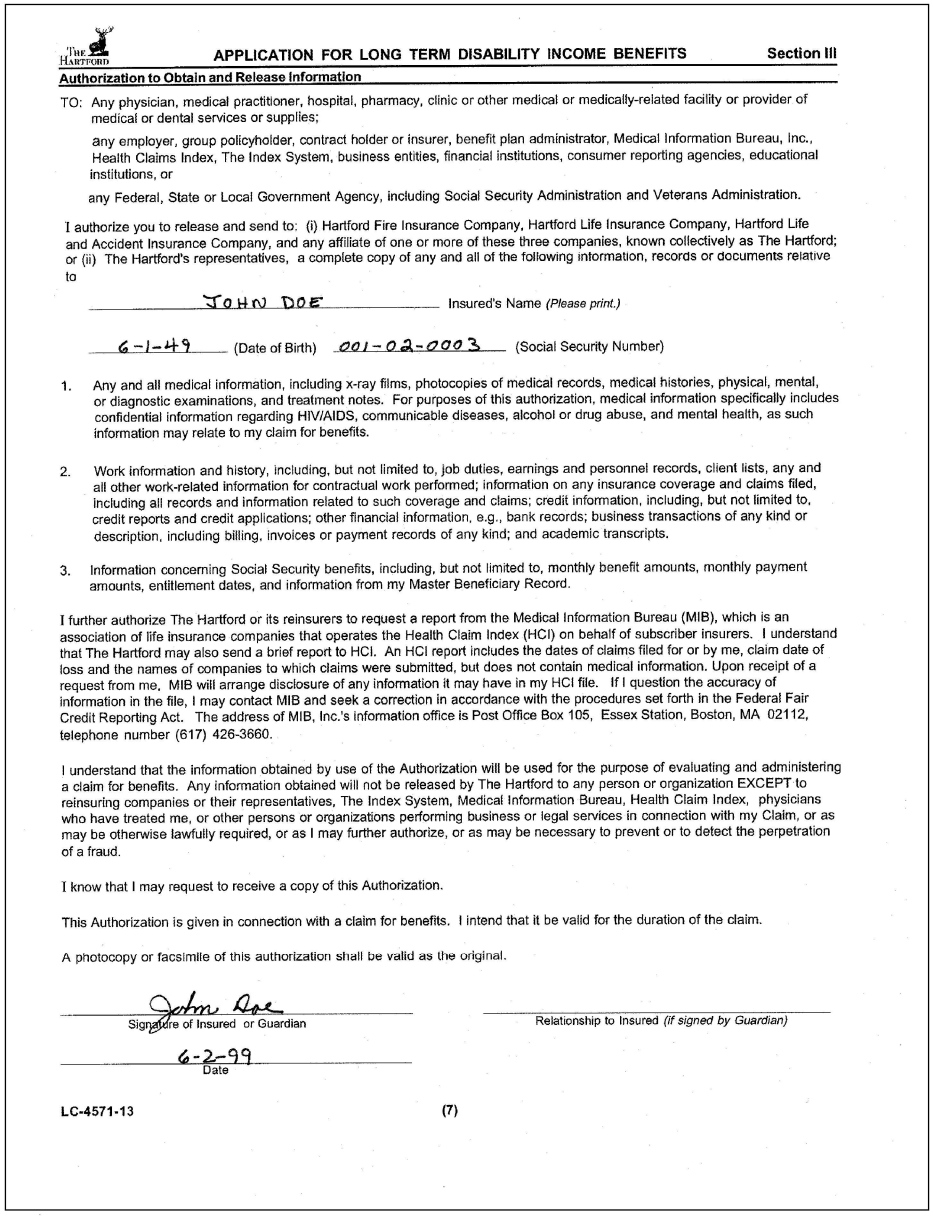
X John Doe
SIGNATURE OF THE EMPLOYEE

X 6-2-99
DATE

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

Authorization to Obtain Information

The employee completes and signs this section.



THE HARTFORD

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS **Section III**

Authorization to Obtain and Release Information

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies;

any employer, group policyholder, contract holder or insurer, benefit plan administrator, Medical Information Bureau, Inc., Health Claims Index, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or

any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize you to release and send to: (i) Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and any affiliate of one or more of these three companies, known collectively as The Hartford; or (ii) The Hartford's representatives, a complete copy of any and all of the following information, records or documents relative to

JOHN DOE Insured's Name *(Please print.)*

6-1-49 (Date of Birth) 001-02-0003 (Social Security Number)

1. Any and all medical information, including x-ray films, photocopies of medical records, medical histories, physical, mental, or diagnostic examinations, and treatment notes. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits.

2. Work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including, but not limited to, credit reports and credit applications; other financial information, e.g., bank records; business transactions of any kind or description, including billing, invoices or payment records of any kind; and academic transcripts.

3. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record.

I further authorize The Hartford or its reinsurers to request a report from the Medical Information Bureau (MIB), which is an association of life insurance companies that operates the Health Claim Index (HCI) on behalf of subscriber insurers. I understand that The Hartford may also send a brief report to HCI. An HCI report includes the dates of claims filed for or by me, claim date of loss and the names of companies to which claims were submitted, but does not contain medical information. Upon receipt of a request from me, MIB will arrange disclosure of any information it may have in my HCI file. If I question the accuracy of information in the file, I may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

I understand that the information obtained by use of the Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by The Hartford to any person or organization EXCEPT to reinsuring companies or their representatives, The Index System, Medical Information Bureau, Health Claim Index, physicians who have treated me, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required, or as I may further authorize, or as may be necessary to prevent or to detect the perpetration of a fraud.

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

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

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

John Doe
Signature of Insured or Guardian

Relationship to Insured *(if signed by Guardian)*

6-2-99
Date

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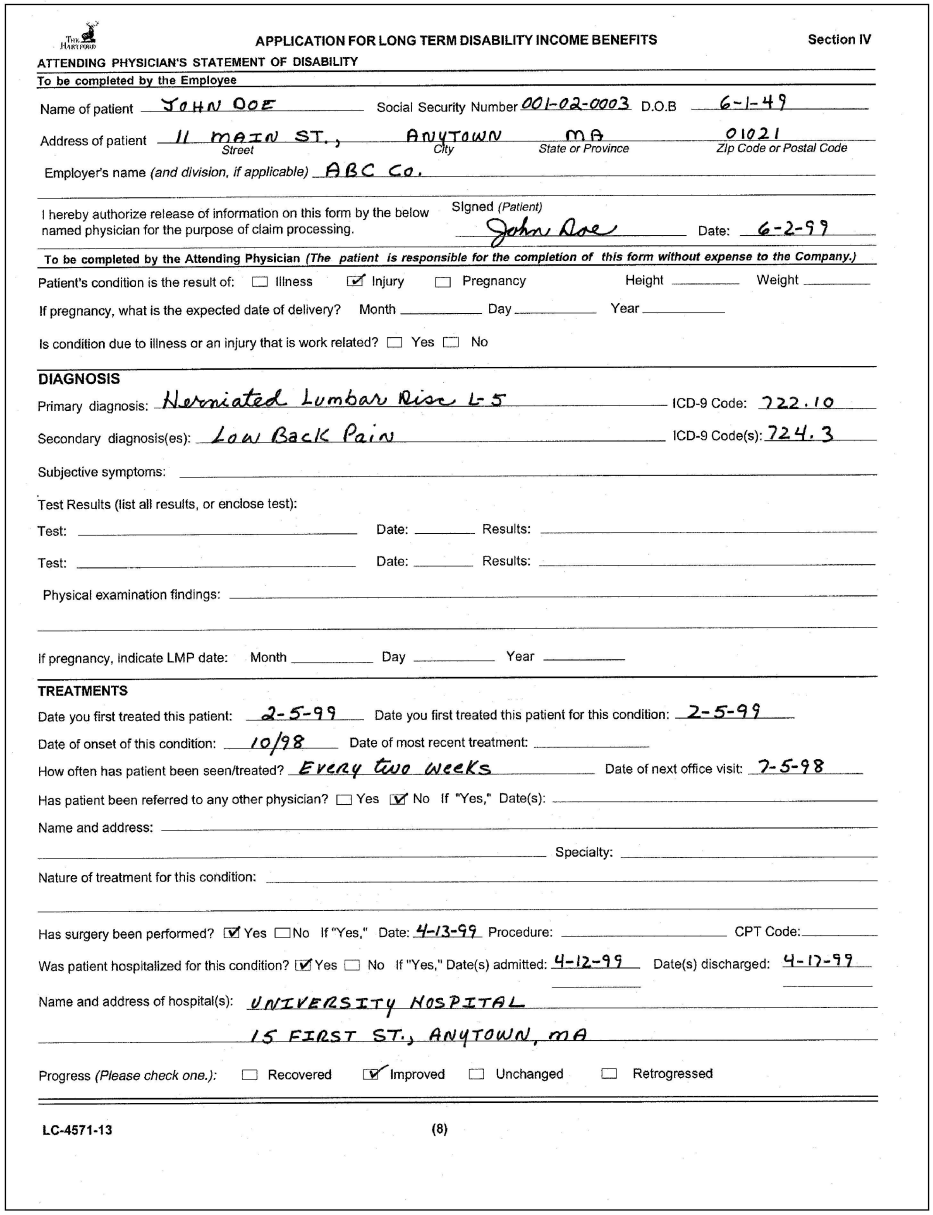
Attending Physician's Statement

The employee fills out the top section, and the employee's physician completes the remaining sections.



The Hartford

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS — **Section IV**

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

To be completed by the Employee

Name of patient JOHN DOE Social Security Number 001-02-0003 D.O.B 6-1-49

Address of patient 11 MAIN ST. (Street), ANYTOWN (City), MA (State or Province), 01021 (Zip Code or Postal Code)

Employer's name *(and division, if applicable)* ABC Co.

I hereby authorize release of information on this form by the below named physician for the purpose of claim processing. Signed *(Patient)* John Doe Date: 6-2-99

To be completed by the Attending Physician ***(The patient is responsible for the completion of this form without expense to the Company.)***

Patient's condition is the result of: ☐ Illness ☑ Injury ☐ Pregnancy Height _____ Weight _____

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

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

DIAGNOSIS

Primary diagnosis: Herniated Lumbar Disc L-5 ICD-9 Code: 722.10

Secondary diagnosis(es): Low Back Pain ICD-9 Code(s): 724.3

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: 2-5-99 Date you first treated this patient for this condition: 2-5-99

Date of onset of this condition: 10/98 Date of most recent treatment: _____

How often has patient been seen/treated? Every two weeks Date of next office visit: 7-5-98

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: 4-13-99 Procedure: _____ CPT Code: _____

Was patient hospitalized for this condition? ☑ Yes ☐ No If "Yes," Date(s) admitted: 4-12-99 Date(s) discharged: 4-17-99

Name and address of hospital(s): UNIVERSITY HOSPITAL, 15 FIRST ST., ANYTOWN, MA

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

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Attending Physician's Statement
(Continued)

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

ATTENDING PHYSICIAN'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: NO MORE THAN 2 HRS IN AN 8 HR DAY

Walking: NO MORE THAN 1/2 HR WITHOUT REST

Sitting: NO MORE THAN 2 HRS IN AN 8 HR DAY

Lifting/carrying: NO MORE THAN 15 LBS

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 4 Day 3 Year 99

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

Attending Physician's Name: RALPH JONES, MD *(Please print or type.)* Telephone # (413) 843-0001

License No. FAX #

SS# or E.I.N.#: 011 11 1111 Degree: MD Specialty: ORTHOPEDICS

Street Address: 5 FIRST ST. City: ANYTOWN State: MA Zip Code: 01021

Signature: Ralph Jones, M.D. Date signed: 6-7-99

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