Group Benefits from The Hartford

Supplemental Life and AD&D Insurance

Benefit Highlights

Florida Department of Revenue

What is supplemental life and AD&D insurance?	Supplemental life and AD&D insurance is coverage that you pay for. Supplemental life and AD&D insurance pays your beneficiary (please see below) a benefit if you die while you are covered. This highlight sheet is an overview of your supplemental life and AD&D insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.
Am I eligible?	You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.
When can I enroll?	You can enroll during your scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of your eligibility waiting period as stated in your group policy.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. You must be actively at work with your employer on the day your coverage takes effect.
How much supplemental life and AD&D insurance can I purchase?	You can purchase supplemental life and AD&D insurance in increments of $10,000. The maximum amount you can purchase cannot be more than 5 times your annual earnings or $300,000. Annual earnings are as defined in The Hartford's contract with your employer.
AD&D Coverage	AD&D provides benefits due to certain injuries or death from an accident. The covered injuries or death can occur up to 365 days after that accident. The insurance pays: • 100% of the amount of coverage you purchase in the event of accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia. • 75% for paraplegia or triplegia (paralysis of three limbs). • One-half (50%) for accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia. • One-quarter (25%) for accidental loss of thumb and index finger of the same hand or uniplegia. Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage you purchase.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing companies Hartford Life Insurance Company, Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company. Home Office is Hartford, CT.

I already have supplemental life and AD&D insurance coverage; do I have to do anything?	If you take no action, your coverage and coverage for your eligible dependents will automatically continue with The Hartford subject to the terms of the contract.
Am I guaranteed coverage?	If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of $80,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.
What is a beneficiary?	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.
Are there other limitations to enrollment?	If you do not enroll within 31 days of your first day of eligibility, you will be considered a late entrant. Typically, late entrants may need to show evidence of insurability and may be responsible for the cost of physical exams or other associated costs if they are required.
Spouse supplemental life insurance	If you elect supplemental life and AD&D insurance for yourself, you may choose to purchase spouse supplemental life insurance in increments of $5,000, to a maximum of $150,000. Coverage cannot exceed 50% of the amount of your employee voluntary/supplemental life insurance coverage. You may not elect coverage for your spouse if they are in active full-time military service or is already covered as an employee under this policy. If your spouse is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of $30,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your spouse's current coverage, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.

Child(ren) supplemental life insurance	If you elect supplemental life and AD&D insurance for yourself, you may choose to purchase child(ren) supplemental life insurance coverage in increments of $2,000, to a maximum of $10,000 for each child – no medical information is required. • If your dependent child(ren) is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. • Child(ren) must be unmarried and their age must be at least 15 days but not yet 19 years (or 25 years if a full time student) to be covered. • Unmarried child(ren) over age 19 may be covered if they are disabled and primarily dependent upon the employee for financial support. • Child(ren) at least 15 days but not yet age 6 months are limited to a reduced benefit of $100.
Does my coverage reduce as I get older?	50% at age 70. All coverage cancels at retirement.
Can I keep my life coverage if I leave my employer?	Yes, subject to the contract, you have the option of: • Converting your group life coverage to your own individual policy (policies).
What is the living benefits option?	If you are diagnosed as terminally ill with a 12 month life expectancy, you may be eligible to receive payment of a portion of your life insurance. The remaining amount of your life insurance would be paid to your beneficiary when you die.
Do I still pay my life insurance premiums if I become disabled?	If you become totally disabled before age 60 and your disability lasts for at least 9 months, your life insurance premium may be waived. The premium for your dependent's coverage will also be waived if you are disabled and approved for waiver of premium. Coverage for your dependents will end if the policy terminates.

Important Details
As is standard with most term life insurance, this insurance coverage includes certain limitations and exclusions:

- the amount of your coverage may be reduced when you reach certain ages.
- death by suicide (two years).

AD&D insurance does not cover losses caused by or contributed by:

- sickness; disease; or any treatment for either;
- any infection, except certain ones caused by an accidental cut or wound;
- intentionally self-inflicted injury, suicide or suicide attempt;
- war or act of war, whether declared or not;
- injury sustained while in the armed forces of any country or international authority;
- taking prescription or illegal drugs unless prescribed for or administered by a licensed physician;
- injury sustained while committing or attempting to commit a felony;
- the injured person's intoxication.

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

This benefit highlights sheet is an overview of the insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the benefit highlights sheet and the insurance policy, the terms of the insurance policy apply.

Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

Florida Department of Revenue

Benefits Enrollment Form, #675266

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter and/or check** your coverage elections. Make sure the coverage amount that you elect includes your existing coverage amount. You may only elect and will be covered for levels of coverage included in your employer's contract.
- **Step 2:** Please **sign, date and return** this form to FLORIDA DEPARTMENT OF REVENUE, HUMAN RESOURCE SERVICES PROCESS, CARLTON BUILDING, ROOM 343, 501 S. CALHOUN STREET, TALLAHASSEE, FLORIDA 32399-0100. Do not mail this form back to The Hartford's address indicated at the top of this form.

Information About You	
Employee Name:	**Employee ID (if not available, then Social Security Number):**
Date of Birth:	
Date of Hire:	

Dependent Information			If more than 4 child(ren), attach additional sheet.
Spouse Name:	**Gender:**	**Spouse Date of Birth:**	**Date of Marriage:**
	☐ M ☐ F		

Child Name:	**Gender:**	**Date of Birth:**	**Child Name:**	**Gender:**	**Date of Birth:**
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

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Prepare today.
Help protect tomorrow.

Name: ____

Supplemental Life and AD&D Insurance

Your cost may change when you move into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.1000	0.1000	0.1200	0.1500	0.2100	0.3200	0.5100	0.8000	1.0400	1.6400	2.8800	4.8700

To calculate your monthly cost, please use the following formula(s):

________________ ÷ $1,000 = __________________ x ____________________ = $____________________

Life and AD&D Benefit Amount — Rate — Monthly Cost

☐ I elect to **purchase** $________________ of life and AD&D coverage.

☐ I **decline** to purchase life and AD&D coverage.

☐ I elect to **continue** my current life and AD&D coverage.

Spouse Supplemental Life Insurance

Costs are based on your spouse's age. Your cost may change when your spouse moves into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0600	0.0600	0.0800	0.1100	0.1700	0.2800	0.4700	0.7600	1.0000	1.6000	2.8400	4.8300

To calculate your monthly cost, please use the following formula(s):

________________ ÷ $1,000 = ________________ x ______________________ = $______________________

Life Benefit Amount — Rate — Monthly Cost

☐ I elect to **purchase** $______________________of life coverage.

☐ I **decline** to purchase life coverage.

☐ I elect to **continue** my current life coverage.

Child(ren) Supplemental Life Insurance

To calculate your monthly cost, please use the following formula(s):

____________ ÷ $1,000 = _______________ x $0.0600 = $_______________

Life Benefit Amount — Rate — Monthly Cost

☐ I elect to **purchase** $__________________ of life coverage.

☐ I **decline** to purchase life coverage.

☐ I elect to **continue** my current life coverage.

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you. A

Name: ____

primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time you die.

PRIMARY BENEFICIARY

Primary Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	
Primary Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	

CONTINGENT BENEFICIARY

Contingent Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	
Contingent Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

Consent For Community Property States Only: If you live in a community property state – **Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin** – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. **Disclaimer:** Spousal consent does not apply to ERISA plans. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will represent that, as spouse of the employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: ______________________________ Date: __________________________

Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit(s) reduce at a specified age(s) stated in the policy.

I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand rates and benefits

Name: ____

may be changed by the insurer.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force.

Fraud Notice(s)
For Residents of Louisiana and Maryland:
Any person who knowingly (knowingly or willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly or willfully in Maryland) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New York (Not applicable to Life Insurance):
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 Virginia:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed__________________________________ Date____________________

PERSONAL HEALTH APPLICATION

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

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

Section 1: Employer Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employer Name:	Policy Number:
Division *(if applicable)*:	
Employer Mailing Address (Street, City, State, Zip Code):	
Benefits Contact Name (First, Last):	
Benefits Contact Email Address:	Benefits Contact Phone: ( ) -

Section 2: Employee Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employee Name (First, MI, Last):

Base Annual Earnings*:	Social Security Number: - -	Date of Hire (mm/dd/yyyy): / /

* Base annual earnings as described in the contract with The Hartford.

Coverage Details

- Check the applicable box(es) in each row to reflect the applicant's current coverage and new election.
- Enter the amount of any **existing** coverage (including Guarantee Issue (GI)**) in **Current Coverage**. Please include the current amount of Basic Life coverage even if the applicant is not requesting Basic Life coverage at this time.
- Enter the amount of **Additional Coverage Requested** that requires medical underwriting.
- Enter the **Total Coverage Amount** that will be in force if the additional coverage requested is approved.
- If the applicant is enrolling after his/her initial eligibility period and does not have current coverage they will be responsible for all fees incurred during the medical underwriting process.

		Current Coverage (including GI Amount)	Additional Coverage Requested	Total Coverage Amount
	Life Insurance Coverage	*Enter all amounts as dollars. Include* ***Basic Life Current Coverage Amount*** *even if not requesting this coverage type.*		
☐	Employee Basic Life	$	$	$
☐	Employee Supplemental or Voluntary Life	$	$	$
☐	Spouse Basic Life	$	$	$
☐	Spouse Supplemental or Voluntary Life	$	$	$

** Guarantee Issue (GI) is the maximum amount of coverage, as defined in the contract with The Hartford, which does not require evidence of good health.

Employees: Please complete pages 2 thru 5. It should take you about 10 minutes to complete this form.

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Applicant Section: Please answer all questions on this page completely and accurately and certify your answers on page 4.
Leaving information blank will result in delays and may result in your file being closed.

Section 3: Employee Information *(Complete even if employee is not applying for coverage)* **PLEASE PRINT CLEARLY**

First Name:	Last Name:	Social Security # : - -
Home Mailing Address (Street, Apt. #):		City:
State:	Zip Code:	Employer:
Daytime Phone: ( )	Evening Phone: ( )	Height: ___Ft. ___In. Weight:________ lbs.
Gender: ☐ M ☐ F	Date of Birth: / /	Email Address:

Section 4: Spouse Information *(Complete only if applying for this coverage)* **PLEASE PRINT CLEARLY**

First Name:	Last Name:	Social Security # : - -
Daytime Phone: ( )	Evening Phone: ( )	Height: ___Ft. ___In. Weight:________ lbs.
Gender: ☐ M ☐ F	Date of Birth: / /	Email Address:

Section 5 – Medical Information *(to be completed only by applicants required to provide evidence of good health)*

If you or anyone proposed for coverage can answer ***Yes*** to any of the Questions below, check the appropriate box and provide **additional details in Section 6.** If you are a **resident of one of the following states:** Connecticut, Florida, Kentucky, Maine, Maryland, Minnesota, New York, North Carolina, Vermont, or Wisconsin then please go to the State Variable Question section on page 3 and answer or review the appropriate question for your state. **After you have read that information, proceed with completing this section**.

Question		
1. Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 work days for the same physical, mental, or emotional condition, disability, injury, or sickness?	☐ Employee	☐ Spouse
2. Within the past 5 years, have you used any controlled substances, with the exception of those prescribed by your physician, received medical advice or sought treatment for drug or alcohol abuse, or been charged with operating a motor vehicle under the influence of drugs or alcohol?	☐ Employee	☐ Spouse
3. Are you currently undergoing any diagnostic testing for symptoms without a final diagnosis or resolution?	☐ Employee	☐ Spouse
4. Are you currently pregnant? If yes, what was your pre-pregnancy weight?_________ lbs.	☐ Employee	☐ Spouse
5. During the past 5 years have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune deficiency disorder?	☐ Employee	☐ Spouse

6. During the past 5 years have you been diagnosed with, treated for, treated with, or had any symptoms due to any of the following conditions or treatments listed below? **Please check all that apply:**

	Employee	**Spouse**		**Employee**	**Spouse**
Heart-Related Surgery or Heart Attack	☐	☐	Crohn's Disease	☐	☐
Stroke	☐	☐	Kidney Failure/Dialysis	☐	☐
Heart Disease (excluding high blood pressure & heart murmur)	☐	☐	Hepatitis (excluding Hepatitis A)	☐	☐
Blocked Arteries (including arteriosclerosis, atherosclerosis, aneurysm, or deep vein blood clot)	☐	☐	Diabetes	☐	☐
Chronic Obstructive Pulmonary Disorder (COPD)	☐	☐	Knee Disorder, Injury, or Surgery	☐	☐
Emphysema	☐	☐	Back or Neck Disorder, Injury, or Surgery	☐	☐
Adjustment Disorder	☐	☐	Joint/Ligament Disorder, Injury, or Surgery	☐	☐
Bipolar Disorder	☐	☐	Osteoporosis or Osteopenia	☐	☐
Depression (single episode)	☐	☐	Multiple Sclerosis (MS)	☐	☐
Depression (multiple episodes)	☐	☐	Amyotrophic Lateral Sclerosis (ALS)	☐	☐
Psychotic/Personality Disorders	☐	☐	Muscular Dystrophy	☐	☐
Other Mental/Nervous/Psychiatric Disorders (including Anxiety)	☐	☐	Arthritis	☐	☐
Cancer (excluding Basal Cell Carcinoma)	☐	☐	Fibromyalgia	☐	☐
Cirrhosis	☐	☐	Chronic Fatigue Syndrome	☐	☐
Ulcerative Colitis	☐	☐	Sleep Apnea	☐	☐

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Employee: First Name_____________________________________ **Last Name**____

Section 5 Continued: State Variable Questions

For residents of Connecticut, Florida, Kentucky, Maine, Maryland, Minnesota, New York, North Carolina, Vermont, and Wisconsin review or answer, where applicable, the question listed below instead of the corresponding question listed in the Medical Information section on **page 2**. Any "Yes" responses can be explained in the Additional Details section of this form. Once you have reviewed/answered these questions, please return to **Section 5** and proceed with completing the rest of the form.

Information to be Reviewed

Florida, Kentucky, and Maryland Residents- Please review this question prior to answering Question 6 in the Medical Information Section on Page 2:

Question 6: During the past 5 years have you been diagnosed with, treated for, or treated with any of the following conditions or treatments listed below? **Please check all of the conditions on page 2 that apply.**

Maine Residents- Please review this statement prior to answering the medical questions in Section 5 on Page 2:

You are not required to disclose whether you have been tested for HIV, if you have not developed symptoms of the disease AIDS or ARC, in your answer to any of the questions in the Medical Information section.

Minnesota Residents- Please review this statement prior to answering the medical questions in Section 5 on Page 2:

You need not disclose an HIV (aids virus) test which was administered: (1) to a criminal offender or criminal victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services.

Please review this question prior to answering Question 6 in the Medical Information Section on Page 2:

Question 6: During the past 5 years have you been diagnosed by a physician with, treated for, or treated with any of the following conditions or treatments listed below? **Please check all of the conditions on page 2 that apply.**

Questions to be Answered

Connecticut and Minnesota Residents: Do not answer Question 2 in the Medical Information section. Answer the following question below.

Question 2: Within the past 5 years, have you used any controlled substances, with the exception of those prescribed by your physician, received medical advice or sought treatment for drug or alcohol abuse, or been convicted of operating a motor vehicle under the influence of drugs or alcohol? ☐ **Employee** ☐ **Spouse**

Florida residents: Do not answer Question 5 in the Medical Information section. Answer the following question below.

Question 5: Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or had unexplained weight loss or enlarged lymph nodes?

☐ **Employee** ☐ **Spouse**

New York Residents: Do not answer Question 5 in the Medical Information section. Answer the following question below.

Question 5: During the past 5 years have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune deficiency disorder excluding HIV?

☐ **Employee** ☐ **Spouse**

North Carolina Residents: Do not answer Question 5 in the Medical Information section. Answer the following question below.

Question 5: Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? AIDS Related Complex (ARC) is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

☐ **Employee** ☐ **Spouse**

Vermont Residents: Do not answer Questions 3 or 5 in the Medical Information section. Answer the following questions below.

Question 3: Are you currently undergoing any diagnostic testing (excluding prior HIV related testing) for symptoms without a final diagnosis or resolution? ☐ **Employee** ☐ **Spouse**

Question 5: Have you been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician?

☐ **Employee** ☐ **Spouse**

Wisconsin Residents: Do not answer Question 3 in the Medical Information section. Answer the following question below.

Question 3: Are you currently undergoing any diagnostic testing, excluding AIDS or HIV tests, for symptoms without a final diagnosis or resolution? ☐ **Employee** ☐ **Spouse**

Please proceed with completing the rest of the medical questions on Page 2 once you have completed/reviewed this page.

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Employee: First Name_________________________________ **Last Name**____

Section 6: Additional Details: If you or anyone proposed for coverage checked any box related to Questions 1 – 6, please provide details in the space below. If you need more space, please attach, sign and date an additional sheet. The Hartford may contact you for additional or missing information.

Question # or Condition	Applicant Name	Medications/ Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name, Address, and Phone #

Section 7: Health Question Certification Statement *(To be completed by all applicants)*

By checking this box: ☐ **Employee** ☐ **Spouse**

I hereby certify that I have reviewed each of the above questions and conditions.
I also certify that I have checked all of the questions and conditions that apply to my health history.

Section 8: Authorization *(To be reviewed by all applicants)*

New York Residents: I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford. I authorize The Hartford to give information about me to: its reinsurer(s); the Medical Information Bureau, Inc.; any other insurance company to whom I may apply for Life or Health Insurance; or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application; or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires 24 months from the date of this application. I understand that a photocopy of this form is as valid as the original and that I have a right to receive a copy of this form upon request.

Residents of All States Except New York: I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford. I authorize The Hartford to give information about me to: its reinsurer(s); the Medical Information Bureau, Inc.; any other insurance company to whom I may apply for Life or Health Insurance; or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application; or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires 24 months from the effective date of my coverage or, if no coverage has been issued, one (1) year from the date of this application. I understand that a photocopy of this form is as valid as the original and that I have a right to receive a copy of this form upon request.

Additional Language for Maine Residents: This authorization excludes disclosure of the result of a test for HIV if the applicant has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS or ARC. I understand that my failure to sign this authorization may impair the ability of The Hartford to process this application or evaluate claims and may be a basis for denying this application or a claim for benefits.

Additional Language for Minnesota Residents: This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or criminal victim as a result of a crime that was reported to the police; (2) to a patient who received the services of Emergency Medical Services personnel at a hospital or medical care facility; or (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "Emergency Medical Personnel" includes individuals employed to provide pre-hospital emergency services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and would qualify for immunity under the Good Samaritan Law.

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Employee: First Name__________________________________ **Last Name**____

Section 9: Certification (*To be reviewed by all applicants*)

Residents of All States: I hereby certify (“**represent” for Kansas residents**) that all statements and answers contained herein, are full, complete, and true to the best of my knowledge and belief.

Residents of All States Except New York: I also understand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the coverage, within the contestable period if such misrepresentation materially affects acceptance of the risk. This information may be used by The Hartford for plan administration purposes to decide if the person(s) is/are eligible for coverage.

I understand that coverage will not become effective until The Hartford grants it’s underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

I agree that this document and all its contents shall form a part of my request for group benefits.

Section 10: Fraud Statement *(To be completed by all applicants)*

Residents of All States Except California, Pennsylvania, and New York: 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.

California Residents: 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**.**

Pennsylvania Residents: 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.

New York Residents: 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.

Notice*:* To the best of their knowledge, an Applicant is required to notify The Hartford in writing of any changes in any applicant’s medical condition between the date the Applicant signs this form and the date the coverage is approved.

________________________________	____/____/____	________________________________	____/____/____
Employee’s Signature or Legal Representative/ Relationship to Employee **(Required)**	**Date Signed**	**Spouse’s Signature** or Legal Representative/Relationship to Spouse **(Required only if applying for coverage)**	**Date Signed**

Please return the completed Employer and Employee sections to:
The Hartford, Medical Underwriting
P.O. Box 2999
Hartford, CT 06104-2999

After submitting this application, you can check your status on line at **www.TheHartfordAtWork.com.**

If you have any questions or concerns, please call The Hartford Customer Service Department toll-free at 1-800-331-7234, Monday through Friday, 8:00 a.m. to 6:00 p.m., Eastern Time, or email us at medical.uw@hartfordlife.com**.**

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