SALAZAR INSURANCE GROUP

THE HARTFORD

THE HARTFORD DISABILITY

Exclusions That Apply to Short or Long Term Disability

Short or Long term disability coverage does NOT cover occupational illness or occupational injuries.

PLEASE MAKE SURE YOU READ THE NEXT PAGE AS IT CONTAINS IMPORTANT INFORMATION ABOUT YOUR DISABILITY CLAIM

Pages 1-8 : Employee Pages 9-10 : BISD Pages 11-12 : Physician

Your elected waiting period is indicated below

(THIS IS THE NUMBER OF CONSECUTIVE DAYS YOU MUST BE OUT OF WORK BEFORE BENEFITS ARE PAYABLE.)

ACCIDENT	SICKNESS	OPTION
0	7	1
14	14	2
30	30	3
60	60	N/A

Your Elected Amount $

Benefit Is Paid Based On The Attending Physician Statement.

Checks are mailed the Last Wednesday of the month

-*The Hartford* takes 15-21 BUSINESS DAYS to make a determination once a COMPLETE PACKET has been received. (This excludes any additional information that would be needed to make the final determination.)

Your waiting period may be waived if you qualify for the 1st day hospital benefit.

This waiver only included in options 1, 2, &3.

SEE PROVISION BELOW AS STATED IN YOUR GROUP DISABILITY SUMMARY OF BENEFITS.

"This feature waives the waiting period if any insured is hospitalized. HOSPITALIZED means that because of your disability you are hospital confined on an INPATIENT basis; then benefits begin the first day of inpatient confinement. (AN OBSERVATION ROOM OR UNIT DOES NOT MEET THIS REQUIERMENT) Inpatient means you are confines to a hospital room due to your sickness or injury for 24 or more consecutive hours for which you are charged a room or board. You must provide the itemized bill from the hospital showing a room charge. If there is no room charge you will not qualify for the waiver.

IF YOU ARE HAVING BARIATRIC SURGARY YOU MUST ALSO PROVIDE THE LETTER OF APPROVAL FROM YOUR INSURANCE COMPANY STATING SURGERY WAS APPROVED DUE TO MEDICAL NESCESSITY

To speak with your assigned The Hartford Disability Benefit Processor for more detail, claim status & benefit payments; call 1-888-301-5615

2039 EAST PRICE ROAD SUITE C BROWNSVILLE, TEXAS 78521
956-554-0028 FAX 956-544-5922

BENEFIT PLAN

Educator Hybrid Long Term Disability Plan

Prepared Exclusively for

What Your Plan Covers and How Benefits are Paid

Other Income Benefits

Other income benefits can affect the monthly benefit described in the long term disability coverage section. When calculating the benefit payable, other income benefits that you, your spouse, your children or your dependents are *eligible* for because of your disability or retirement are taken into consideration.

After the first 6 months of disability payments, other income benefits considered when your benefits payable are calculated include:

- Disability, retirement or unemployment benefits required or provided for by government law. This includes (but is not limited to):
  - Unemployment compensation benefits.
  - Automobile no-fault wage replacement benefits required by law.
  - Benefits under the Federal Social Security Act, Railroad Retirement Act, Canada Pension Plan and Quebec Pension Plan.
  - Veteran's benefits.

Recovery of Overpayments Long Term Disability Coverage

If payments are made in amounts greater than the benefits that you are entitled to receive, Aetna has the right to do any one or all of the following:

- Require you to return the overpayment on request;
- Stop payment of benefits until the overpayment is recovered;
- Take any legal action needed to recover the overpayment; and
  - Place a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

Exclusions That Apply to Long Term Disability

Long term disability coverage does not cover any disability on any day that you are confined in a penal or correctional institution for conviction of a criminal act or other public offense. You will not be considered to be disabled, and no benefits will be payable.

Long term disability coverage also does not cover any disability that:

- **Is due to occupational illness or occupational injury.**
- Is due to insurrection, rebellion, or taking part in a riot or civil commotion.
- Is due to intentionally self-inflicted injury (while sane or insane).
- Is due to war or any act of war (declared or not declared).
- Results from your commission of, or attempting to commit a criminal act.
- Results from a motor vehicle accident caused by operating the vehicle while you are under the influence of alcohol

Schedule of Benefits

Maximum Benefit Duration*

- If your period of disability starts prior to the date you reach age 60, it will end the last day of the calendar month in which you reach age 65, after the elimination period is met.
- If your period of disability starts on or after the date you reach age 60, it will end with the expiration of 60 months of disability, after the elimination period is met.

*Unless your disability ends earlier for one or more of the reasons stated in your Booklet-Certificate.

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

THE HARTFORD

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 Name: Middle Initial: | Date of Birth: | Social Security Number:

Address: (Street, City, State & Zip Code) | Gender: ☐ Male ☐ Female

E-Mail Address:

E-Mail is used to provide The Hartford At Work registration instructions and important status updates.

Personal Cell Telephone Number: ( ) Alternate Telephone Number: ( )

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No

Signature Date

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed | 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: (Check one)

☐ HS/GED ☐ Trade School/Certification Program ☐ AA/AS ☐ BA/BS ☐ Masters ☐ Doctorate ☐ Some college

☐ Other List all licenses, certifications, majors

Have you served in the military? ☐ Yes ☐ No

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

Dates Employed	Employer	Job Title	Duties

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)

Legal Spouse's Name: (Last, First)

Legal Spouse's Social Security Number: | Date of Birth: (Month/Day/Year) | Is your legal spouse employed? ☐ Yes ☐ No | Retired? ☐ Yes ☐ No

Do you have any children under Age 19? ☐ Yes ☐ No If "Yes," please provide the information requested below for each child.

Name: Date of Birth: Social Security Number:

Name: Date of Birth: Social Security Number:

Name: Date of Birth: Social Security Number:

Do you have any children with disabilities (regardless of age)? ☐ Yes ☐ No If "Yes," please provide the information requested below for each child

Name: Date of Birth: Social Security Number:

Name: Date of Birth: Social Security Number:

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 this activity.

Height: _____ **Weight:** _____

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 Healthcare Provider?
_____ (Month/Day/Year)

Name of Healthcare Provider:

Address of Healthcare 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 work activities or your workplace? ☐ 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.

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

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

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

E. Information About Healthcare Providers and Hospitals

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

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

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

Healthcare Provider's Name:	Telephone: ( ) Fax: ( )	Specialty:
Address: (Street, City, State & Zip)		Dates seen: **to**
Hospital:		
Address: (Street, City, State & Zip)		Dates of Confinement: **to**

E. Information About Healthcare Providers and Hospitals (Cont...)

Have you consulted any other Healthcare 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)

Healthcare Provider'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: Disability/Retirement	$ _____ / _____	_____	_____	_____
Social Security: Widow's/Widower's	$ _____ / _____	_____	_____	_____
Sick Pay or Salary continuation	$_____ / _____	_____	_____	_____
Income from Work	$_____ / _____	_____	_____	_____
Workers' Compensation	$_____ / _____	_____	_____	_____
State Disability	$_____ / _____	_____	_____	_____
Pension: Disability/Retirement	$_____ / _____	_____	_____	_____
Public Employee/State Teacher: Retirement/Disability	$_____ / _____	_____	_____	_____
Short Term Disability	$_____ / _____	_____	_____	_____
Unemployment	$_____ / _____	_____	_____	_____
No-Fault Insurance	$_____ / _____	_____	_____	_____
Other (include individual Group Benefits or Veteran's Benefits)	$_____ / _____	_____	_____	_____

Are you paying for Medicare Part D? ☐ **Yes** ☐ **No** **If "Yes," please enter amount:** _____**. 00.**

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. **IMPORTANT:** If you pay the entire cost of the LTD premium, but on a Post-tax basis per Section I, Part D of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed state Tax Withholding Certificate from you. Please contact your employer or state Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed federal Form W-4, Employee's Withholding Allowance Certificate, from you. You may go to www.irs.gov to obtain the proper withholding form.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the second 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 Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, 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 Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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

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

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

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

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

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

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading 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 Ohio: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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 thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

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

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

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

The statements contained in this form are true and complete to the best of my knowledge and belief.

_____ _____

Signature Date

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local , and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford, the following personal, private, or privileged information, records, or documents:

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security or other government benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and /or leave request(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as "My Information."

I understand that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. I authorize The Hartford to use or disclose My Information (i) to my employer for: a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud (all entities and individuals listed herein including The Hartford defined as "Benefits Manager(s)")

I understand that My Information disclosed to Benefits Managers pertaining to certain alcohol or drug abuse treatment or HIV/AIDS or other communicable or sexually-transmitted disease is protected by federal (42 CFR Part 2) and state confidentiality rules and statutes, which prohibit any further disclosure of this information without my express written consent, or as otherwise permitted by such rules and statutes. I understand that a general authorization for the release of medical or other information is NOT sufficient for release of these types of records.

Therefore:

☐ **If any of my records contain information about alcohol or drug abuse, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the benefits program. I understand that the federal rules restrict any use of the Information to criminally investigate or prosecute any drug or alcohol abuse patient.**

☐ **If any of my records contain information about HIV/AIDS or other communicable or sexually transmitted disease, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the benefits program.**

(Continue to next page)

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, respond to regulatory or similar complaints, or protect the personal safety of others or myself.

If I change my mind about this Authorization before that time is up, I can tell my Records Holders and The Hartford in writing that I do not want them to share any more information with other parties. If I revoke my Authorization by telling them in writing to stop sharing information with other parties, it will not change any actions they took before I revoked my permission. If I do not sign this Authorization, it will not affect how my health care providers treat me. However, if I do not sign, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I know I can see or copy the records given to The Hartford based on this Authorization. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

NOTICE TO INFORMATION PROVIDERS:
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.*

Claimant's Name	**Date of Birth**
Employer's Name	**Date**
Claimant's (or Legal Representative's) Signature	**Legal Representative's Name and Relationship**

Form must be signed in order to be considered valid.

SALAZAR INSURANCE GROUP

I _____ (Employee/ Claimant name), authorize The Hartford to release information regarding my claim to the below mentioned Staff of

Salazar Insurance Group

Leti Martinez (Account Executive)

Robert (Bob) Daniels (District Manager)

_____ _____

EMPLOYEE/CLAIMANT SIGNATURE **DATE**

_____

PRINTED NAME OF LEGAL REPRESENTATIVE / BENEFICIARY

_____ _____

SIGNATURE OF LEGAL REPRESENTATIVE / BENEFICIARY **DATE**

***COMPLETE OVER THE PHONE WITH EMPLOYEE BENFITS (956)548-8061

Clear Form

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

THE HARTFORD

Employer's Section - 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)		Telephone Number: ( )

A. Information About the Employer

Company's Name: Brownsville ISD		Group Policy Number: 803820
Address:1900 E. Price Rd. Room 212, Brownsville, TX 78521	Telephone Number: (956 548 8061)	Fax Number: ( )
Name and address of division where employee works: (if different from above)	Class:	Location:

B. Information About the Employee

Date employee was hired:	Date employee became insured under this plan:	What was the employee's regularly scheduled work week? _____ 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: _____	Is the employee a union member ? ☐ Yes ☐ No If Yes, name of union and local number:

C. Information for Group Life PremiumWaiver Benefits

Does the employee also have Group Life Insurance coverage with The Hartford? ☐ Yes ☐ No If "Yes," provide the following information: Basic Amount $_____ Supplemental Amount $_____ Dependent Amount $_____
Effective Date of Group Life Insurance coverage: _____

D. Information Needed for Withholding and Reporting Taxes

What percent of this employee's LTD benefits is taxable? _____%.
What percentage, if any, do you contribute towards the cost of the LTD premium?_____%
Does the employee contribute towards the cost of the LTD premium? ☐ Yes ☐ No
If "Yes," is it on a ☐ Pre or ☐ Post Tax basis?

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?	How long has the employee been in this job ?
Why did employee stop working?	Is the employee's condition work related? ☐ Yes ☐ No
Last day employee actually worked:	On that day, did the employee work a full day? ☐ Yes ☐ No If "No," how many hours were worked? _____
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: _____ 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 contribution ☐ Profit Sharing ☐ Defined benefit ☐ 401 K ☐ 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? _____

At what point does the employee qualify for a full pension? _____

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

*****COMPLETE OVER THE PHONE WITH EMPLOYEE BENFITS (956)548-8061**

xG. 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?

H. Information About the Employee's Salary

Basic Salary or wage immediately prior to cessation of work because of disability: (exclude bonuses, overtime, pay, etc.)
$_____ ☐ Annually ☐ Monthly ☐ Bi-Weekly ☐ Weekly ☐ Hourly Number of Hours/Week: _____

Is this employee eligible for salary continuation? ☐ Yes ☐ No or Sick Pay? ☐ Yes ☐ No
If "Yes," what is the bi-weekly amount? $_____ When do benefits begin? _____ End? _____

Will the employee file for Short Term Disability? ☐ Yes ☒ No 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.
Select either majority of workday or sporadically.

Activity	Majority of workday (with standard breaks)		Sporadically throughout day	If sporadically circle time for each section below: Hours at one time	Total hours/8 hour
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

Can the job be performed alternating sitting and standing? ☐ Yes ☐ No

Activity	Never	Occasionally (1-33%)	Frequently (34-67%)	Constantly (68-100%)
Driving	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Bending at Waist	☐	☐	☐	☐
Kneeling/Crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Climbing	☐	☐	☐	☐

Lift/Carry/Push/Pull: Task Description (Describe object moved and any mechanical assistance in the last column)					
Lifting		lbs.	lbs.	lbs.	
Carrying		lbs.	lbs.	lbs.	
Pushing/Pulling		lbs.	lbs.	lbs.	

Upper Extremity Activity (not load bearing)	**Specify right (R) or left (L) if not bilateral)**				**Describe task performed**
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

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:

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

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).

Name (Please print or type) _____ Title _____

Signature _____ Date _____

***Please fax the completed form to (956)544-5922

Clear Form

ATTENDING PHYSICIAN'S STATEMENT

THE HARTFORD

To be completed by the Employee

Patient Name:	Date of Birth:	Insured ID Number:

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

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

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

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

Is condition due to illness or an injury that is related to: ☐ Work Activity ☐ Motor Vehicle Accident

Medical Conditions Impacting Activity

Primary condition: _____ ICD-9 Code: ☐ _____

ICD- 10 Code: ☐ _____

Secondary condition(s): _____ ICD-9 Code: ☐ _____

ICD-10 Code(s): ☐ _____

Subjective symptoms: _____

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

_____

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

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Condition(s) Specific Medications, Dosage and Frequency:

_____

_____

Treatments

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

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

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

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

Current Treatment Plan: _____

_____

Has surgery been performed? ☐ Yes ☐ No Is surgery planned? ☐ Yes ☐ No If "Yes," Date: _____

Procedure: _____ CPT Code: _____

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," Date(s) admitted: _____ Date(s) Discharged: _____

Name of Hospital: _____ Telephone Number of Hospital: (____) _____

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

Other Physician Name: _____ Phone Number: (____) _____ Specialty: _____

Other Physician Name _____ Phone Number: (____) _____ Specialty: _____

Patient Name: Date of Birth: Insured ID Number:

Complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

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

Restrictions/Limitations based on office visit dated: _____

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

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

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

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

Please attach copies of imaging results/tests

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

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

Additional Comments (If Necessary): _____

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

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

Provider's Name: (please print or type)	EIN Number:	License Number:

Telephone Number: ( )	Fax Number: ( )	Degree:	Specialty:

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

Office Contact and Telephone Number:

Provider's Signature: Date signed: