Clear Form

HARTFORD LIFE NSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT NSURANCE COMPAN

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

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

Section IG **Employer's Statement -** to be Sompleted by he employer's authorized representative.S Be sure to provide any necessary atSachments (see Section K).S

Section Ic.G nformation for Group Life Premium Waiver Benefits - to be Sompleted by theS employer's authorized representative if he employer also has a Group Life InsuranceS policy with The Hartford that includes a Premium Waiver benefit. Be sure o provideS any necessary atSachments (see Section K)S

Section IIG **Employee's Statement -** to be Sompleted by the employee who is applying for Long TermS Disability benefits. Please attach a Sopy of he employee's driver's license.S

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

Section IVG **Attending Physician's Statement -** to be Sompleted by the physician who is treating theS employee.S

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THG COMPLGTGDG APPLICATION TO:G

The McKellan Group, ncG
1449 Old Waterbury Rd #201
Southbury, CT 06488

Claim Questions: 800.531.2001G
Fax To: 203.575.0308G

THE HARTFORD

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Section I
Employer's Statement

Mail to: The McKellan Group, Inc.
1449 Old Waterbury Rd
Suite #201
Southbury, CT 06488

Questions 1-800-531-2001 / Fax# 203-575-0308

To be Completed by the Employer

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

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

A. Information About the Employer

Company's Name | Group Policy Number

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

Name and address of division where employee works *(if different from above)* | Fax Number

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 _____

C. Information for Group Life Premium Waiver 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 $ _____

Effective Date of Group Life Insurance coverage _____

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? _____ %. *(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? | How long had the employee been in this job?

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

Why did employee stop working? | 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? _____ (*Month, Day, Year*)

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

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

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?

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.)
$ _____ ☐ Monthly ☐ Weekly ☐ Annually ☐ Hourly # Hours/Week _____

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

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.

_____ _____ %
_____ _____ %
_____ _____ %

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.
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*

THE HARTFORD

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

Section II
Employee's Statement

Mail to: The McKellan Group, Inc.
1449 Old Waterbury Rd
Suite #201
Southbury, CT 06488

Questions 1-800-531-2001 / Fax# 203-575-0308

To Be Completed by the Employee (**BE SURE TO k SWER k ALL QUESTIONS— FkILURE TO DO SO MkY DELkY YOUR CLkIM)k**

A. Information about youL

Last named | Firsth | Middle Initialh | Social Securhity Numbeh

Ad ress *(Street)Y* | Cityh | State/Provinceh | Ziph

Telephone Numberd

Date of Birth *(Month, Day, Year)Y* | Heightd | Weightd | ☐ Ma ed ☐ Fema ed | ☐ Sing ed ☐ Married | ☐ Widowed ☐ Divorced

Your employer *(include division, f applicable)Y* | Occupationh

When your disability began, did you have more than one employer *(includes lf-employment)* ? ☐ Yes ☐ No. If "Yes," p eased provide the name, address and phone number of that employer. Indicate the dates when you worked *(or were lf-employed)* .d

Please indicate the extent of your formal education *(Circle one)Y*

High School:d 1 2 3 4 5 6 7 8 9 10 11 12d

Co ege 1 2 3 4d Mastersd _____ Ph.D.d _____

Trade School:d _____ Current Occupational Licenses:d _____

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

Job Titlek	Dutiesk	Years Workedk
(a)h		
(b)h		
(c)h		

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work?d ☐ Yesd ☐ Nod

Have you contacted your State Department of Vocational Rehabilitation? ☐ Yes ☐ No If "Yes," p ease inc ude the name, address and telephone number of your counselor.d

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

Spouse's Name *(Last, first)Y*

Spouse's Social Security Numberd | Date of Birth *(Month, Day, Year)* | Is your spouse employed? ☐ Yes ☐ Nod | Retired?d ☐ Yes ☐ Nod

Do you have any chi dren under Age 19?d ☐ Yes ☐ No If "Yes p ease provide the information requested be ow for each chi d.d

Named_____ Date of Birthd_____ Social Security Numberd_____

Named_____ Date of Birthd_____ Social Security Numberd_____

Named_____ Date of Birthd_____ Social Security Numberd_____

Do you have any children with disabilities *(regardless of age)*? ☐ Yes ☐ No If "Yes," p ease provide the information requested be ow for eachd child.

Named_____ Date of Birthd_____ Social Security Numberd_____

Named_____ Date of Birthd_____ Social Security Numberd_____

C. Information About the Condition Causing Your DisabilityL

1a. For illness, Lnswer the following questions:L

What were your first symptoms?d

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

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**

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

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.

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 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.

Mail to: The McKellan Group, Inc.
1449 Old Waterbury Rd
Suite #201
Southbury, CT 06488
Questions 1-800-531-2001 / Fax# 203-575-0308

THE HARTFORD

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

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, 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., 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

Mail to: The McKellan Group, Inc.
1449 Old Waterbury Rd
Suite #201
Southbury, CT 06488
Questions 1-800-531-2001 / Fax# 203-575-0308

THE HARTFORD

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

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

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: _____

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: _____

The McKellan Group, Inc.

AUTHORIZATION AND AGREEMENTS

This form authorizes the below-named persons and organizations to release information about your claim to your Employer and to The McKellan Group, Inc., the employer's claims administrator. The authorization on this form must be given by the person claiming plan benefits (you, the "claimant") or the claimant's legal representative.

This form must be signed by the claimant or the claimant's legal representative in order for the claim submission to be administered by The McKellan Group, Inc.

Claimant's Full Name: _____ SSN: ☐☐☐-☐☐-☐☐☐☐

Employer: _____ Location: _____

TO all physicians and other medical professionals, hospitals and other medical-care institutions and psychiatric-care institutions, and to governmental agencies. insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators:

YOU ARE AUTHORIZED to provide the above-named Employer and the benefit plan and/or claims administrator with information concerning medical care, advice, treatment or supplies provided to the claimant, and any employment-related information regarding the claimant. This information will be used for the purpose of evaluating and administering the claim for benefits. A verbal interview is also authorized. A copy of this authorization shall have the same authority as the original.

I UNDERSTAND that the duration of this authorization is for the term of coverage under the Plan under which my claim for disability benefits has been submitted. I ALSO UNDERSTAND that I have a right to receive a copy of this authorization upon request.

I ACKNOWLEDGE that the Plan includes provisions reserving the right to reduce Plan benefits payable to me by amounts paid or payable to me by other disability program benefits, including but not limited to Social Security Disability and Retirement benefits. I acknowledge the advantage of having the Plan pay my regular benefits until such time as I receive any such additional benefits. I realize that when I receive any additional benefits, an overpayment may occur on my claim. I AGREE A) that I will apply for Social Security Disability benefits and for other disability programs benefits payable for my disability as required by the Plan, B) that I will immediately notify the claims administrator when awarded such benefits, and C) that I will pay back to the Plan all amounts of such payments over and above the amounts through which I would be entitled under the Plan provisions.

I ALSO AGREE that neither the filing of this claim nor the payment of benefits by or on behalf of the Employer under any Sick Pay, Salary Continuance, Short-Term Disability, or Long-Term Disability plan shall constitute an admission of any liability for payment thereunder, or a waiver of any conditions of any such plan. I further understand that I may be required to participate in one or more Independent Medical Examinations (IMEs) in connection with my claim.

X _____ _____

Claimant's or Legal Representative's Signature Date

CLAIMS ADMINISTERED BY: **THE McKELLAN GROUP, INC.**
1449 Old Waterbury Rd #201
Southbury, CT 06488
1-800-531-2001
Fax 203-575-0308