Completing your Personal Health Application – New York Applicants

Purpose

These instructions will help you to complete your Personal Health Application. This will help ensure that your application is processed accurately and timely.

Instructions

After you complete the application, mail the application to:

The Hartford Medical Underwriting P.O. Box 2999 Hartford, CT 06104-2999

Please write your name in the space provided at the top of pages 3 and 4, and make a copy of the completed application for your records.

Section 3

- Enter Employer's name in space provided.
- Complete the **Employee Information** section.
- If your spouse is applying for coverage, have your spouse complete the Spouse Information section.

Section 5

Give details for all boxes checked in Section 4. If more space is needed, then attach, sign and date an additional sheet.

Column	Action
Question # or Condition	Enter the question number or condition/treatment name in the first column.
Applicant	Enter the name of the person to which the condition/treatment pertains.
Medications/Treatment	Enter a short description of the medication/treatment received as a result of the condition.
Date of Diagnosis	Enter the date on which the applicant was diagnosed.
Date of Last Symptom	Enter the date the applicant last experienced a symptom of the condition.
Current Status of Condition	Enter a brief description of the condition's status as of today.
Physician's Name, Address, and Phone #	Enter the name, address and phone number of the physician the applicant went to in reference to this condition/treatment.

Section 6 - 8

- Read these sections in their entirety.
- Upon review and completion of the application, please sign and date the bottom of the page in the space provided.
- If your spouse has applied for coverage on this application, he/she must sign and date the bottom of the page in the space provided.

Contact Information

We are here when you need us. If you have any questions about your application, please contact us at **(800) 331-7234** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, or e-mail us at medical.uw@hartfordlife.com.



PERSONAL HEALTH APPLICATION

HARTFORD LIFE INSURANCE COMPANY

200 Hopmeadow Street, Simsbury, Connecticut 06089

Section 1: Employer Details (to be completed by the Employer)					PLEASE PRINT CLEARLY				
Employer Name:					Policy Number:				
Division (if applicable):				•					
Employer Mailing Address (Street,	City, State, Zip Code):								
Benefits Contact Name: (First, Las	t)								
Benefits Contact Email Address:			Benef	ts Contact Pho	one:				
Section 2: Employee Detail Prefilled information has been proved correct. If you find an error, please Employee Name: (First, MI, Last)	ils (to be completed by the Envided to Hartford Life Insurance Coross off the erroneous information	nploye Compar ion, fill	r) ny by Employer. F in the correct info	lease verify th	is info late ar	PLEASE PRINT CLEARLY rmation is ad initial the change(s).			
Base Annual Earnings*: \$	Social Security Nu	mhor:		Data of I	Date of Hire (mm/dd/yyyy):				
 Enter the amount of any exist amount of Employee Basic Lift Enter the amount of Addition 	vriting process.	e is not quires r dditiona oes not	sue (GI)**) in Cur requesting Basic medical underwrit al coverage reque have current cov	rent Coverage Life coverage ng. ested is approverage they ma	e. Plea at this ed.	estime.			
	Current Coverage (including GI Amount)	+	Additional Reque		=	Total Coverage Amount			
Life Insurance Coverage	Enter all amoun	Enter all amounts as dollars. Include Basic Life Current Coverage Amount even if not requesting this coverage type.							
Employee Basic Life		+			=				
Employee Supplemental Life		+			=				
Spouse Basic Life		+			=				
Spouse Supplemental Life		+			=				

The Hartford® is Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies in New York are underwritten by Hartford Life Insurance Company.

^{**}Guaranteed Issue (GI) is the maximum amount of coverage, as defined in the contract with Hartford Life Insurance Company, which does not require evidence of good health.

Section 3: Applicant Information								
Employer:								
Employee Information (Complete even if employee	oyee is <u>not</u> applyii	ng for co	verage)			PLE/	ASE PRINT CLE	ARLY
First Name:		Last Na	ame:					
Social Security Number:			Height:	Ft	ln.	Weight	Ibs.	
Home Mailing Address (Street, Apt. #):								
City:			State:			Zip Code:		
Daytime Phone:	Evening Phone:	Gender:					□ M □ F	
Date of Birth: Email Address								
Spouse Information (Complete only if applying	g for this coverage	e)				PLEA	ASE PRINT CLE	ARLY
First Name:		Last Na	ame:					
Social Security Number:			Height:	Ft	ln.	Weight	lbs.	
Daytime Phone:	e: Gender: □ M □ F							
Date of Birth:	Email Address:							

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Employee: First Name								
Section 4 Medical Information (to be completed only by applicants required to provide evidence of good health) If you or anyone proposed for coverage can answer <u>Yes</u> to any of the Questions below, check the appropriate box and provide details in the Additional Details section.								
1. To the best of your knowledge and belief 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? □ Spouse □ Spouse								
2. During 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 while under the influence of drugs or alcohol? ☐ Employee ☐ Spouse								
	3. To the best of your knowledge and belief during the past 5 years have you undergone any diagnostic testing for symptoms without a final diagnosis or resolution?							
To the best of your knowledge and be If yes: What was your pre-pregnancy	·	ently pregnant?		☐ Employee	☐ Spouse			
5. To the best of your knowledge and belief 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) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV?								
. To the best of your knowledge and belief 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 Appea					

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Employee: First	t Name		Last N	lame		
	e, please attach, si	Is: If you checked any begin and date an addition.				in the space below. If you act you for
Question # or Condition	Applicant	Medications/ Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name, Address, and Phone #
Section 6 Cer	rtification (To be	e reviewed by all applica	nts)			
I hereby certify the best of my knowless.		I the above questions ar	nd all statements	and answers con	ained herein are f	ull, completed, and true to the
Section 7 Aut	thorization (To I	pe reviewed by all applic	cants)			
whom I may appl	ly for Life or Health	Company to give informations in the company to give information in the company to the company to give information in the company to give i	sons or organiza	tions handling a c		e company to ing coverage applied for or for
authorization. Th	nis authorization ex		ne date of this ap	plication. I unders		ly been taken in reliance on this copy of this form is as valid as
PRE-EXISTING	CONDITIONS LIM	ITATION – Applicable	to Disability Ins	urance Only		
excludes coveraç	ge for a period of ti	rance, I understand tha me if I have a pre-existional information regardin	ng condition as de	efined on the date	my coverage bec	
Section 8 Fra	ud Statement -	- Applicable to Disabil	ity Insurance Or	nly (To be reviewe	ed by <u>all</u> applicants	\$)
claim containing commits a fraudu	any materially false	e information, or conceat, which is a crime, and s	ls for the purpose	e of misleading, in	formation concern	n for insurance or statement of ing any fact material thereto, ve thousand dollars and the
		dge, an Applicant is required				
This application v	will be made a part	of the Policy.				
			1			
or Lega Relation	byee's Signature al Representative/ nship to Employee (Required)	Date	Signed	or Legal Relatio	se's Signature Representative/ nship to Spouse f applying for co	Date Signed verage)

Employee: First Name



NOTICE OF INSURANCE INFORMATION PRACTICES

PLEASE READ AND RETAIN THIS NOTICE OF INSURANCE INFORMATION PRACTICES FOR YOUR RECORDS.

In order to properly underwrite and administer your application for insurance coverage, we must collect certain information concerning your insurability. You are our most important source of information, but we may also contact other sources such as medical professionals and institutions, employers and other insurance companies. While all information regarding your insurability will be treated as confidential, in some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

INVESTIGATIVE CONSUMER REPORTS

As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. You have the right to send a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

PERSONAL HISTORY INTERVIEW

To provide you, our client, with the best possible service, we may also conduct what we call a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the application information is complete. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

ACCESS, CORRECTION AND DISCLOSURE

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Also, please be advised that personal and confidential information collected by us may, in certain circumstances, be disclosed to third parties without authorization. A notice providing further description of the circumstances under which information about you may be disclosed and the types of persons and organizations to whom it may be disclosed will be sent to you upon your written request. If you desire further information or access to your personal information, please send your written request to: Hartford Life Insurance Company or Hartford Life and Accident Insurance Company, 200 Hopmeadow St., Simsbury, CT 06089.

Underwriting Companies: Hartford Life Insurance Company or Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies is Simsbury, CT.