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

Save | Print | Clear Employee

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: Le Moyne College	Policy Number: 677763
Division (if applicable):	
Employer Mailing Address (Street, City, State, Zip Code): 1419 Salt Springs Road, Syracuse, NY 13214	
Benefits Contact Name: (First, Last) Zubieta, Amy	
Benefits Contact Email Address: zubietak@lemoyne.edu	Benefits Contact Phone: 315-445-4156

Section 2: Employee Details (to be completed by the Employer)

PLEASE PRINT CLEARLY

Prefilled information has been provided to Hartford Life Insurance Company by Employer. Please verify this information is correct. If you find an error, please cross off the erroneous information, fill in the correct information, and date and initial the change(s).

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 Hartford Life Insurance Company.

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 Guaranteed Issue (GI)**) in **Current Coverage**. Please include the current amount of Employee Basic Life coverage even if the Employee 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 may 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 Life		+		=	
Spouse Basic Life		+		=	
Spouse Supplemental Life		+		=	

**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.

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.

Section 3: Applicant Information

Employer: Le Moyne College

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

First Name:	Last Name:	
Social Security Number:	Height: ____Ft.____In.	Weight_____ lbs.
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 for this coverage) **PLEASE PRINT CLEARLY**

First Name:	Last Name:	
Social Security Number:	Height: ____Ft.____In.	Weight_____ lbs.
Daytime Phone:	Evening Phone:	Gender: ☐ M ☐ F
Date of Birth:	Email Address:	

Employee: First Name _____ Last 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 **Yes** 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?	☐ Employee	☐ 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?	☐ Employee	☐ Spouse
4. To the best of your knowledge and belief are you **currently** pregnant? If yes**:** What was your pre-pregnancy weight? _____	☐ 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?	☐ Employee	☐ Spouse

6. 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 Apnea	☐	☐

Employee: First Name _____ Last Name _____

Section 5: Additional Details: If you 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. Hartford Life Insurance Company may contact you for additional or missing information.

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 Certification (To be reviewed by all applicants)

I hereby certify that I have reviewed the above questions and all statements and answers contained herein are full, completed, and true to the best of my knowledge and belief.

Section 7 Authorization (To be reviewed by all applicants)

I authorize Hartford Life Insurance Company to give information about me to: its reinsurer(s), any other insurance company to whom I may apply for Life or Health Insurance, or other persons or organizations handling a claim, for underwriting coverage applied for or for administering coverage issued as a result of this application; or as required to 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.

PRE-EXISTING CONDITIONS LIMITATION – Applicable to Disability Insurance Only

With respect to group disability insurance, I understand that the policy/certificate may include a pre-existing condition provision that limits or excludes coverage for a period of time if I have a pre-existing condition as defined on the date my coverage becomes effective. I also understand that I may obtain additional information regarding this provision by referring to the group policy and/or certificate.

Section 8 Fraud Statement – Applicable to Disability Insurance Only (To be reviewed by all applicants)

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 Hartford Life Insurance Company 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.

This application will be made a part of the Policy.

_____	/ /	_____	/ /
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**

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.