



Hartford Life

## PERSONAL HEALTH STATEMENT

Employees must complete this form if they have requested insurance coverage for themselves or any of their family members and are required to show evidence of good health.

For questions about how to complete this form, call Hartford Life at  
**800-331-7234**

### Instructions

#### Employer's Responsibility

1. Fill out the Employer Section completely. An incomplete form cannot go forward. [Refer to your Policy Contract and employee records. These records are your property and are not on file with Hartford Life's Group Medical Underwriting Department.]
2. In Section #1 "Who Requires a Personal Health Statement?" indicate with a check mark all who are required to provide evidence of good health – employee, spouse or child – and for each, check the reason(s) why. Consult your Policy Contract for all requirements, limitations and exceptions.
3. In Section #2 "Coverage Summary," fill in all coverage amounts for each applicant. **Basic Life coverage amounts are important and must be included for all applicants requesting additional Life coverage.** Consult your employee records to determine current coverage amounts.
4. After completing the Employer section, give the entire form, including both the Employer and Employee Sections, to the employee to complete.
5. No premiums should be deducted until a final decision regarding coverage is received from Hartford Life's Group Medical Underwriting Department.

#### Employee's Responsibility

1. Make sure your Employer has already completed the Employer Section of this form in full.
2. The Employer Section clarifies which applicants need to show evidence of good health and be listed on the Personal Health Statement. Refer to "Who Requires a Personal Health Statement?" in the **Employer Section** of the form where a box has been marked for each person who is required to fill out the Personal Health Statement – you (the employee), your spouse, or your child. Enter the names of these individuals on the Personal Health Statement under "Applicants Requiring Health Evaluation," and fill in the information requested.
3. Answer all questions completely and accurately. Even seemingly minor details like height and weight are very important and must be accurate.
4. Understand that an employee who has enrolled as a "Late Entrant" (shown in the Employer Section #1) is responsible to pay for the cost of physical exams or medical tests if they are required now or are requested during the application process.
5. **YOU, THE EMPLOYEE, MUST SIGN THIS APPLICATION** (even if you yourself are not applying for coverage). Use your full legal signature, and enter the date signed. Your spouse must sign this application **ONLY** if using this form to apply for coverage. He or she must use a full legal signature, and enter the date signed.
6. **BOTH THE EMPLOYER AND EMPLOYEE SIDES OF THIS FORM MUST BE RECEIVED BY HARTFORD LIFE WITHIN 30 DAYS OF THE SIGNATURE DATE.** The information on the form will be considered "current" for not more than 90 days. That's why it's important to fill out the form completely. Leaving information blank can result in delays or can even result in your application being closed.
7. Upon completion:
  - SEND BOTH LEFT AND RIGHT SIDES OF THE TOP, **WHITE COPY** – INCLUDING THE EMPLOYER SECTION AND THE EMPLOYEE SECTION – TO:  
Hartford Life  
Group Medical Underwriting  
PO Box 2999  
Hartford, CT 06104-2999
  - Return both left and right sides of the **BLUE** copy to your employer. (Note that areas containing personal medical history have been blocked out on the copy for your employer.)
  - Keep the **YELLOW** applicant's copy for your records.

# Employer Section

# Personal Health Statement

Please print in dark ink. Initial any changes.

Company Name

Division Name (If Applicable)

Mailing Address

City ST Zip Policy Number

Contact Person Telephone Number E-Mail

Employee Name Employee Social Security Number

## 1. Who Requires a Personal Health Statement

Check box of each applicant who requires evidence of good health with a Personal Health Statement (PHS), and specify the reason(s) why: **Check all reasons that apply:**

### Identify Applicants Requiring a Personal Health Statement

- |                              |   |   |   |
|------------------------------|---|---|---|
| <p><b>E</b><br/>Employee</p> | <p><b>Late Entrant</b> <input type="checkbox"/><br/>(employee did not enroll during eligibility period – usually 31 days from date of hire)</p>   | <p><b>Over Guaranteed Issue Limit</b> <input type="checkbox"/><br/>(coverage up to this limit does not require evidence of good health)</p> | <p><b>Opted up to higher level of coverage</b> <input type="checkbox"/><br/>(e.g. from 1- to 2 times earnings)</p>          |
| <p><b>S</b><br/>Spouse</p>   | <p><b>Late Entrant</b> <input type="checkbox"/><br/>(did not enroll during eligibility period or within 31 days of a change in family status)</p> | <p><b>Over Guaranteed Issue Limit</b> <input type="checkbox"/><br/>(coverage up to this limit does not require evidence of good health)</p> | <p><b>Opted up to higher level of coverage</b> <input type="checkbox"/><br/>(e.g. from \$10,000 – \$20,000 of coverage)</p> |
| <p><b>C</b><br/>Child</p>    | <p><b>Late Entrant</b> <input type="checkbox"/><br/>(did not enroll during eligibility period or within 31 days of a change in family status)</p> | <p><b>Over Guaranteed Issue Limit</b> <input type="checkbox"/><br/>(coverage up to this limit does not require evidence of good health)</p> | <p><b>Opted up to higher level of coverage</b> <input type="checkbox"/><br/>(e.g. from \$10,000 – \$20,000 of coverage)</p> |

Refer to your Policy Contract and employee records for coverage amounts, eligibility period (for Late Entrant determination), Guaranteed Issue limits, exceptions for salary increases and rules for “opting up.”

## 2. Coverage Summary

For each applicant, complete all three columns. **Life Coverages:** Be sure to include Basic Life coverage amounts for all applicants requesting additional life coverage. Refer to employee records for Current Coverage Amounts (usually for Life coverage calculate 1,2,3 (etc.) times annual earnings to arrive at the dollar amount). **Disability Coverages:** Refer to employee records for the benefit percentage selected and calculate what that percentage is of their annual salary. Then calculate the monthly benefit amount (divide by 12) for LTD and/or the weekly benefit amount (divide by 52) for STD.

Applicants for Life Coverage	Current Coverage Amount	Additional Amount Applied For	Total Coverage
<b>Employee:</b>			
Basic Life	\$ __, __ __ __ __, __ __ __ __	\$ __, __ __ __ __, __ __ __ __	\$ __, __ __ __ __, __ __ __ __
Suppl. Life or Voluntary Life	\$ __, __ __ __ __, __ __ __ __	\$ __, __ __ __ __, __ __ __ __	\$ __, __ __ __ __, __ __ __ __
<b>Spouse:</b>			
Basic Life	\$ __, __ __ __ __, __ __ __ __	\$ __, __ __ __ __, __ __ __ __	\$ __, __ __ __ __, __ __ __ __
Suppl. Life or Voluntary Life	\$ __, __ __ __ __, __ __ __ __	\$ __, __ __ __ __, __ __ __ __	\$ __, __ __ __ __, __ __ __ __
<b>Dependent:</b>			
Child Life	Cumulative for __ (how many?) children \$ __, __ __ __ __, __ __ __ __	Cumulative for __ (how many?) children \$ __, __ __ __ __, __ __ __ __	Cumulative for __ (how many?) children \$ __, __ __ __ __, __ __ __ __
<b>Applicants (employees only) for Disability Coverage</b>	<b>Current Benefit Amount</b>	<b>Additional Benefit Amount</b>	<b>Total Benefit Amount</b>
Employee: Long Term Disability	\$ __ __ __, __ __ __ __ per month	\$ __ __ __, __ __ __ __ per month	\$ __ __ __, __ __ __ __ per month
Employee: Short Term Disability	\$ __ __ __, __ __ __ __ per week	\$ __ __ __, __ __ __ __ per week	\$ __ __ __, __ __ __ __ per week

# Employee Section

# Personal Health Statement

Please print in dark ink. Initial any changes.

Employee Name - First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Occupation \_\_\_\_\_

Daytime Telephone \_\_\_\_\_ E-Mail \_\_\_\_\_

**BEFORE MAILING**  
 • Check that all questions are answered, form is dated and signed.  
 • Keep a copy for your records.  
**MAIL THIS FORM - BOTH LEFT & RIGHT SIDES OF THE TOP, WHITE COPY TO:**  
 Hartford Life  
 Group Medical Underwriting  
 P.O. Box 2999  
 Hartford, CT 06104-2999

## 1. Applicants Requiring Health Evaluation

List below the names of applicants identified in Employer Section 1.

First Name, MI, Last Name	Employee/Spouse/Child	HEIGHT (ft/in) Required	WEIGHT (lbs) Required	DATE OF BIRTH	SEX
_____	<input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> C	_____	_____	____-____-____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	<input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> C	_____	_____	____-____-____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	<input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> C	_____	_____	____-____-____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	<input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> C	_____	_____	____-____-____	<input type="checkbox"/> M <input type="checkbox"/> F

## 2. Health Questions

Questions 1-24 are to be answered collectively by all Applicants listed above; i.e. if any one Applicant answers Yes to a question, mark the [Y] answer. Otherwise, mark [N] for No. For all Yes answers, provide additional detail below.

During the past 10 years have you:

- |  |  |  |
|--|--|--|
| 1. Had any surgery or been told to have surgery? <input type="checkbox"/> Y <input type="checkbox"/> N                       | 3. Had any injuries from a car accident, or filed a workers' compensation claim? <input type="checkbox"/> Y <input type="checkbox"/> N | 5. Consulted or been examined by any doctor or other medical practitioner? <input type="checkbox"/> Y <input type="checkbox"/> N       |
| 2. Been in a hospital or other institution for diagnosis or treatment? <input type="checkbox"/> Y <input type="checkbox"/> N | 4. Been declined for any life or disability insurance coverage? <input type="checkbox"/> Y <input type="checkbox"/> N                  | 6. Have you had any lab test, X-ray, electrocardiogram or other diagnostic test? <input type="checkbox"/> Y <input type="checkbox"/> N |

During the past 10 years have you at any time been treated or told you had a problem with any of the following:

- |  |   |   |
|--|---|---|
| 7. Heart, chest pain, abnormal pulse, high blood pressure, stroke, heart murmur, blood or circulatory, or vascular conditions? <input type="checkbox"/> Y <input type="checkbox"/> N | 15. Drug or alcohol abuse, or used alcohol or nicotine on a regular basis? Indicate number per day. <input type="checkbox"/> Y <input type="checkbox"/> N | 21. "AIDS," AIDS-related complex, or been tested positive for the antibodies to the AIDS virus, or do you have enlarged lymph nodes or unexplained weight loss? <input type="checkbox"/> Y <input type="checkbox"/> N |
| 8. Cancer or tumors, or leukemia? <input type="checkbox"/> Y <input type="checkbox"/> N  | 16. Eyes, ears, nose or throat? <input type="checkbox"/> Y <input type="checkbox"/> N   | <b>Currently:</b>   |
| 9. Diabetes, thyroid, liver, glands, or spleen? <input type="checkbox"/> Y <input type="checkbox"/> N  | 17. Psychiatric, mental, nervous disorders, including depression? <input type="checkbox"/> Y <input type="checkbox"/> N                                   | 22. Are you pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N   |
| 10. Asthma, bronchitis, allergies, pneumonia, or respiratory problems? <input type="checkbox"/> Y <input type="checkbox"/> N   | 18. Back, spine, bones, muscles, connective tissue, ligaments, tendons or joints? <input type="checkbox"/> Y <input type="checkbox"/> N                   | 23. Are you taking medication for any condition or disease? <input type="checkbox"/> Y <input type="checkbox"/> N   |
| 11. Ulcers, stomach, rectum, intestines, gallbladder, upper or lower digestive system? <input type="checkbox"/> Y <input type="checkbox"/> N   | 19. Immune system, anemia or other blood conditions? <input type="checkbox"/> Y <input type="checkbox"/> N  | <b>Important:</b>   |
| 12. Arthritis or Rheumatism? <input type="checkbox"/> Y <input type="checkbox"/> N   | 20. Brain or nervous system problems, or epilepsy? <input type="checkbox"/> Y <input type="checkbox"/> N  | 24. Any symptoms, injury, birth defect, congenital defect, disease or disorder not mentioned above? <input type="checkbox"/> Y <input type="checkbox"/> N   |
| 13. Kidneys, bladder or urinary tract? <input type="checkbox"/> Y <input type="checkbox"/> N   |   |   |
| 14. Genital or reproductive organ problems? <input type="checkbox"/> Y <input type="checkbox"/> N  |   |   |

**Notice: Applicant is required to notify Hartford Life in writing of any changes in the applicant's medical condition between the date the applicant signs this form and the date coverage is approved. FOR EACH "YES" ANSWER ABOVE, IDENTIFY THE QUESTION NUMBER, APPLICANT NAME AND PROVIDE DETAILS REQUESTED:**

Question No. _____	Applicant Name _____	Medical Condition _____	Date Sought Treatment _____	Duration of Condition _____	Treatment _____
Current Status _____	Physician's Name, Street, City, State and Zip Code _____				
Question No. _____	Applicant Name _____	Medical Condition _____	Date Sought Treatment _____	Duration of Condition _____	Treatment _____
Current Status _____	Physician's Name, Street, City, State and Zip Code _____				
Question No. _____	Applicant Name _____	Medical Condition _____	Date Sought Treatment _____	Duration of Condition _____	Treatment _____
Current Status _____	Physician's Name, Street, City, State and Zip Code _____				

If additional space is required, please attach a separate sheet. Sign and date each sheet.

Important: See reverse side. Your signature indicates that you have read this important information.

**BOTH THE EMPLOYER AND EMPLOYEE SIDES OF THIS FORM MUST BE RECEIVED BY HARTFORD LIFE WITHIN 30 DAYS OF THE SIGNATURE DATE. ITS INFORMATION WILL BE CONSIDERED CURRENT FOR NO LONGER THAN 90 DAYS FROM THE SIGNATURE DATE.**

I hereby certify that the above statements and answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the persons to whom the statements and answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits. This information may be used by the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company (for full-insured coverages) or my employer/administrator (for self-funded coverages), to decide if the person(s) is eligible for coverage.

I authorize any physician, medical or health practitioner, counselor, therapist, hospital, clinic or other medical or medically-related facility, insurance or reinsurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer that has records or knowledge of me or my health or my children or their health to give the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its legal representative, any non-medical information or medical information that relates to: 1) Pre-existing or current illnesses, sicknesses, diseases, disabilities, disorders, accidents, injuries or any other health conditions; 2) Confinements in hospitals, medical facilities, or medical clinics; 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners; 4) Drug abuse, alcohol abuse, or mental health protected by Federal Law; 5) Counseling or therapy; for the purpose of determining eligibility for insurance or eligibility for benefits under an existing policy. This information will be treated as confidential. I acknowledge that I have read all the information on the reverse side of this page.

X \_\_\_\_\_ DATE SIGNED \_\_\_\_\_ X \_\_\_\_\_ DATE SIGNED \_\_\_\_\_  
 EMPLOYEE'S SIGNATURE (required) SPOUSE'S SIGNATURE (required only if applying for coverage)

I **authorize** the Hartford Life Insurance Company or Hartford Life and Accident Insurance Company to release information in its file to the Medical Information Bureau, Inc., and other insurance companies to whom I or my children may apply for Life or Health Insurance, or other persons or organizations, performing business or legal services in connection with this application or a claim, or as may be otherwise lawfully required. Except as specified, this information will not be given, sold or transferred to any person without first obtaining my consent on a written form stating the use and need for such information.

I **understand** that upon written request, I am entitled to receive details of the procedures I must use to implement my right to access, correct and amend any personal information collected about myself or my children in connection with this application.

I **understand** that if I request details about any medical record information collected about myself in connection with this application, the medical record information and the identity of the medical care institution, or medical professional that provided the information, shall be supplied only to a licensed medical professional designated by me, unless otherwise authorized by the medical professional or institution who provided such information.

I **understand** that upon written request, I may revoke this authorization except to the extent that action has already been taken in reliance on the consent.

I **understand** that this authorization will expire two years from the date of the policy or that this authorization will expire one year from the date of signature, if no policy has yet been issued.

I **understand** a photographic copy of this authorization shall be as valid as the original.

I **understand** that misstatements, misrepresentations, or omissions in my response to the request for information above may result in the voiding of coverage under this plan as of the effective date, with no benefits payable in the event.

### **MEDICAL UNDERWRITING DISCLOSURE FORMAT**

The following summary of information practices is being provided in accordance with our policy on privacy.

#### **Collection of Information**

In order to properly underwrite your request for group benefits, we must collect certain information about your physical condition.

You are the most important source of information about your own health, and to the degree it is possible, we will rely on only information obtained from you. If we do find we are required to contact medical professionals or institutions, we will contact them directly using the authorization on the front side of this form.

#### **Disclosure**

Information we collect about you will not be given to anyone without your consent, except when it is necessary for conducting our business. The only people who have access to the information are employees who service your benefits or claims and those who have a regulatory or legal need for the information. In other situations, we will ask you for written authorization to disclose information about you.

#### **Access and Correction**

In most cases the only information we will collect is provided by you. You are encouraged to keep a copy of this form for your records. If we find it is necessary to contact medical providers or institutions, there are procedures by which you can obtain access to the personal information about you which we have collected. Upon written request, we will provide you with information in your file. Medical information will be disclosed only through a physician you designate, unless otherwise authorized by the medical professional or institution who provided such information to us. Details regarding your right to correct or amend information in your file will be furnished upon written request.

We hope you find this summary helpful. If you have any further questions about privacy policy and practices, please write to:

**HARTFORD LIFE**  
**Group Medical Underwriting**  
**P.O. Box 2999**  
**Hartford, CT 06104-2999**

We take our responsibilities in handling your personal information very seriously.