The Hartford
P.O. Box 14301
Lexington, KY 40512-4301
Telephone Number (888) 485-7336
Fax Number (866) 411-5613

DISABILITY CLAIM FORM

Clear Form

THE HARTFORD

Please print or type. Answer all questions fully and date the form to avoid delays.
(Complete this side of the form and give it to your doctor)

EMPLOYEE INFORMATION

Employee's Name (Last, First, Middle Initial)	Birth Date	Social Security Number	Occupation
Address (Street, Apt. Number, City, State & Zip Code)		E-Mail Address	
Spouse's Name (Last, First, Middle Initial)	Birth Date		
Youngest Dependent's Name (Last, First, Middle Initial)	Birth Date	Is child disabled ☐ Yes ☐ No	

Home Phone Number ( )	Work Phone Number ( )	Cell Phone Number ( )
Supervisor Name (Last, First)		Supervisor's Phone ( )
Work Address (Street, City, State & Zip Code)		

Highest education level completed (check one)
☐ Grade School ☐ College/University
☐ High School ☐ Graduate School
☐ Vocational School ☐ Post-Graduate School

Employee, please attach a copy of your driver's license or document that verifies your date of birth.

CLAIM INFORMATION

1. Is your disability due to: ☐ Injury/Accident* ☐ Illness ☐ Pregnancy**?
   *If due to injury/accident, provide date _____ time _____ and details (when, where, how)

   **If due to pregnancy, estimated delivery date: _____ 2. Is your condition work-related? ☐ Yes ☐ No

3. Date of first treatment of this condition	Date last worked	Date Disability Began	Height	Weight
/ /	/ /	/ /		

4. Name and address of your primary attending physician:

5. Name all physicians/providers who have treated you for this condition (or similar condition) during the past two years.

Name of Physician/Provider	Phone Number	Dates of Treatment	Reason for Visit
	( )	From To	
	( )	From To	
	( )	From To	

6. Have you been in the hospital for this condition? ☐ Yes* ☐ No
   *If "Yes," give dates: From _____ To _____
   Name and address of hospital

OTHER INCOME

Are you receiving any of the following sources of income? If "Yes," please indicate below:

Source of Income	Yes	No	Amount Paid	Date Payments Started
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)	☐	☐	$	

The physician who is treating you for your current condition must sign the back of this form before benefits can be considered.

I hereby authorize release of information on this form by the below named physician for the purpose of claim processing:
Signed *(Patient)* _____

ATTENDING PHYSICIAN'S STATEMENT

This section must be completed and signed by the attending physician. Please answer all the questions fully and return this form to the patient or The Hartford promptly. A claims representative may contact you if additional information is needed. If you need additional space, attach a separate sheet. Both sides of this form must be fully completed in order to process this claim.

A. History

Symptoms result from: ☐ injury ☐ illness ☐ Pregnancy* Is condition work related? ☐ Yes ☐ No

*Pregnancy delivery date: Expected _____ Actual _____ Type of Delivery: _____

Initial Date of Treatment _____ Most recent treatment date _____

Did you advise the patient to cease his/her occupation as stated on this form? ☐ Yes ☐ No If "Yes, date: _____

B. Diagnosis and Treatment

Primary ICD-9: _____ DIAGNOSIS _____

Secondary ICD-9: _____ DIAGNOSIS _____

Subjective symptoms:

Objective/Testing findings:

Current and recommended treatment plans:

If surgery is performed/anticipated: CPT-4 _____ Procedure _____ Date _____

Current medication & treatments prescribed (provide names/dosages):

C. Prognosis

1. The patient has been continuously disabled (unable to work) from ___/___/___ through ___/___/___
2. Have you advised patient to return to work? ☐ Yes* ☐ No
   *If "Yes," expected date of return ___/___/___ ☐ To regular occupation ☐ Full time ☐ Part time
   ☐ To any other occupation ☐ Full time ☐ Part time

D. Physical Capabilities

1. Patient's ability to:

	Hours (check)		
Sit	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently
Stand	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently
Walk	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently

2. Patient's ability to:

Climb	☐ Yes	☐ No
Twist/bend/stoop	☐ Yes	☐ No
Reach above shoulder level	☐ Yes	☐ No
Operate a motor vehicle	☐ Yes	☐ No

3. Patient's ability to lift/carry:

	Never 0%	Occasionally 1-35%	Frequently 36-66%	Continuously 67-100%
Up to 10lbs.	☐	☐	☐	☐
11 to 20lbs.	☐	☐	☐	☐
21 to 50lbs.	☐	☐	☐	☐
51 to 100lbs.	☐	☐	☐	☐
Over 100lbs.	☐	☐	☐	☐

4. Patient's ability to perform repetitively:

	Right Hand		Left Hand	
Fine finger movements	☐ Yes	☐ No	☐ Yes	☐ No
Eye/hand movements	☐ Yes	☐ No	☐ Yes	☐ No
Pushing/Pulling	☐ Yes	☐ No	☐ Yes	☐ No

Dominant Hand ☐ Right ☐ Left

5. Patient can work a total of hours _____ per day

6. In your opinion, why is the patient unable to perform his/her job duties?

7. Do you expect improvement in any area? ☐ Yes ☐ No If "Yes," please comment and give dates/time frames.

PHYSICIAN'S SIGNATURE

Physician's Name (please print)	Tax ID Number (required)	Phone ( )
Address (street, City, State & Zip Code)		Fax Number ( )

Physician's Signature _____ Date _____

Signature - Please read the statement that applies to your state of residence and sign the bottom of the 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 California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, 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 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, Virginia 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 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.

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.

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

Signature _____ Date _____

PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR ANOTHER DOCUMENT THAT VERIFIES YOUR DATE OF BIRTH.

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

To: Any health care provider, employer, benefit plan, insurer, service provider, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to The Hartford[1] a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

Insured's Name (*Please print*)	Date of Birth	Last 4 Digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental, or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits and bank records; business transactions billing, invoice, and payment records; academic transcripts; and information concerning Social Security 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 for the purpose of evaluating and administering my claim for benefits and/or leave request. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

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 disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to complaints by me or my representative relating to benefits or leave; d) responding to any litigation or agency document production request or lawful subpoena; e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers of my employer's benefit plan, other benefits, and/or leave programs of my employer for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan 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; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; or (ix) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make, unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. 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 or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian	Date	Relationship to Insured (*if signed by Guardian*)

[1] The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, and Hartford Life and Accident Insurance Company, and administrative services companies Hartford-Comprehensive Employee Benefit Service Company and Specialty Risk Services, LLC , and any of their parents, affiliates, subsidiaries and/or third-party contractors.

Comments

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