

# CLAIMANT QUESTIONNAIRE

(Read instructions carefully before completing this form.)



Policyholder/Employer	Policy Number
Claimant	Social Security Number

**Part I. Personal Profile Evaluation** (Please complete this form to the best of your ability. If you need additional space, please attach additional pages. Sign and date the form and promptly return it in the self-addressed envelope enclosed.)

**1. Please describe your most current medical condition or conditions (including the specific limitations or restrictions that they place on your ability to work).**

Has there been a change in your condition in the last 18 months?  No  Yes If "Yes," please describe the specific change or changes.

**2. Please list all of the types of activities that you do during the course of a typical day. What do you specifically do from the time you arise in the morning until you retire at night? Do you require assistance with any of your daily activities?**

No  Yes If "Yes," describe:

**3. Please provide the following information about the condition causing your disability. 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 of them: 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.**

- ( ) Dress                      ( ) Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene  
 ( ) Toilet                      ( ) Feed yourself with food that has been prepared and made available to you.  
 ( ) Bathe (tub, shower, or sponge)              ( ) Transfer from Bed to Chair

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.

What is your Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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?  No  Yes If "Yes," describe:

**4. What kinds of hobbies or social/community activities did you engage in prior to your Disability?**

Have you continued to engage in any of these activities since you became Disabled and/or do you presently continue with any of these activities?  No  Yes If "Yes," please list the hobbies or social/community activities and how often you participate in them.

**5. Do you own a personal computer?**  No  Yes If "Yes," please provide the following information:

What types of programs are you proficient in?  Word  Excel  Other \_\_\_\_\_

Do you have an e-mail address?  No  Yes \_\_\_\_\_

Do you have your own web-site?  No  Yes \_\_\_\_\_

**Part I. Personal Profile Evaluation (continued...)**

**6. Have you engaged in any work activity (including self-employment) since the onset of your Disability?**  No  Yes  
**If "Yes," please indicate:**

Name of the employer (including your business, if self-employed)	
Address of the employer (Street, City, State & Zip Code)	Dates of employment
Essential job duties	Gross monthly earnings
If self-employed, does your business also have an e-mail or web-site address? If "Yes," what are they? <input type="checkbox"/> No <input type="checkbox"/> Yes	

**7. Do you expect to be engaged in any work activity (including self-employment)?**  No  Yes **If "Yes," please indicate:**

Name of the employer (including your business, if self-employed)	
Address of the employer (Street, City, State & Zip Code)	Dates of employment
Essential job duties	

**8. Have you continued your education or vocational training since the onset of your Disability?**  No  Yes **If "Yes," please advise:**

Name of the educational or vocational institution	Courses of study
Address of the educational or vocational institution	
Degrees or certificates received if any, or expected to receive.	Current occupational licenses

**9. Has there been a change in your marital status since the onset of your Disability?**  No  Yes **If "Yes," indicate the nature of the change:**

**10. Please list the names, dates of birth and social security numbers of your spouse and any dependent children under age 19.**

_____ (Spouse)	_____ (Date of Birth)	_____ (Social Security Number)
_____ (Child)	_____ (Date of Birth)	_____ (Social Security Number)
_____ (Child)	_____ (Date of Birth)	_____ (Social Security Number)
_____ (Child)	_____ (Date of Birth)	_____ (Social Security Number)

**11. Please list the names(s), address(es) and telephone number(s) of any physicians that you have consulted and/or been treated by within the last 18 months.**

_____ (Name)	_____ (Address)	( ) (Telephone Number)
_____ (Name)	_____ (Address)	( ) (Telephone Number)
_____ (Name)	_____ (Address)	( ) (Telephone Number)
_____ (Name)	_____ (Address)	( ) (Telephone Number)

**12. If you have been hospitalized within the last 18 months, please list the name(s), address(es), of the hospital(s) and confinement dates.**

_____ (Name)	_____ (Address)	_____ (Dates of Confinement)
_____ (Name)	_____ (Address)	_____ (Dates of Confinement)
_____ (Name)	_____ (Address)	_____ (Dates of Confinement)

**Part II. Other Income Questionnaire (Please check the appropriate box and complete the information for any of the following other income items that you have received, are currently receiving, expect to receive, or are eligible to receive.)**

		DATE BENEFITS STARTED	DATE BENEFITS ENDED	GROSS AMOUNT (Weekly, Monthly)
<b>WAGES</b> Wages Salary or Remuneration received from:	<input type="checkbox"/> Any employer	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Self Employment	_____	_____	\$ _____ per _____
<b>INSURANCE</b> Disability Benefits received from:	<input type="checkbox"/> Group Life Insurance	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Disability Income Policy purchased or available through an Employer, Association or Group (other than Hartford)	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Pension/Retirement Plan (from any employer)	_____	_____	\$ _____ per _____
	<input type="checkbox"/> No-Fault Disability Income	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Individual Disability Policy	_____	_____	\$ _____ per _____
<b>GOVERNMENTAL SOURCES</b> Disability Benefits received from:	<input type="checkbox"/> Federal Social Security Act	_____	_____	\$ _____ per _____
	<input type="checkbox"/> - Self	_____	_____	\$ _____ per _____
	<input type="checkbox"/> - Spouse	_____	_____	\$ _____ per _____
	<input type="checkbox"/> - Children	_____	_____	\$ _____ per _____
	<input type="checkbox"/> - Others	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Canada/Quebec Pension Plan	_____	_____	\$ _____ per _____
	<input type="checkbox"/> - Self	_____	_____	\$ _____ per _____
	<input type="checkbox"/> - Dependents	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Workers' Compensation	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Railroad Retirement Act	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Civil Service Retirement Act	_____	_____	\$ _____ per _____
	<input type="checkbox"/> The Jones Act	_____	_____	\$ _____ per _____
<input type="checkbox"/> Black Lung	_____	_____	\$ _____ per _____	
<input type="checkbox"/> Any other Governmental Program	_____	_____	\$ _____ per _____	
<b>RETIREMENT SOURCES</b> Retirement Benefits under:	<input type="checkbox"/> Federal Social Security Act	_____	_____	\$ _____ per _____
	<input type="checkbox"/> - Self	_____	_____	\$ _____ per _____
	<input type="checkbox"/> - Spouse	_____	_____	\$ _____ per _____
	<input type="checkbox"/> - Children	_____	_____	\$ _____ per _____
	<input type="checkbox"/> - Others	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Railroad Retirement Act	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Any Pension Plan (present/prior)	_____	_____	\$ _____ per _____
<input type="checkbox"/> Military Retirement Program	_____	_____	\$ _____ per _____	
<b>OTHER</b>	<input type="checkbox"/> Unemployment Compensation	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Income from any 3rd party action or settlement	_____	_____	\$ _____ per _____
	<input type="checkbox"/> Any other income (not listed in above)	_____	_____	\$ _____ per _____

Are you paying for Medicare Part D?  Yes  No If "Yes," please enter amount: \$ \_\_\_\_\_ .00.

**PART III Signature**

With the exception of any source(s) of income reported in Part II 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, New York, Virginia and Puerto Rico:** 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.** (In Oregon, a fraudulent insurance act may be a crime.) The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

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**For residents of New Jersey, Arkansas, and New Mexico:** 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 an insurance policy is subject to criminal and civil penalties.

**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 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.

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**For residents of Louisiana:** 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 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 Puerto Rico:** Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**For residents of Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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

Claimant Signature \_\_\_\_\_ Date \_\_\_\_\_

Claimant Address \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

**PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR ANOTHER DOCUMENT THAT VERIFIES YOUR DATE OF BIRTH, UNLESS IT WAS PREVIOUSLY PROVIDED TO US.**

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**



To: Any health care provider, employer, benefit plan, insurer, 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<sup>1</sup> 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 5 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, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and 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, bank records; business transactions billing, invoices, 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 under my employer's benefit plan. 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 ALSO 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 any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; or e) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (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 or legal services related my claim; (vi) as may be lawfully required; or (vii) as may be necessary to prevent or detect perpetration of a fraud.

I 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 or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. 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

\_\_\_\_\_  
Relationship to Insured (*if signed by Guardian*)

\_\_\_\_\_  
Date

<sup>1</sup> The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and its administrative services company Hartford-Comprehensive Employee Benefit Service Company, and any of their parents, affiliates, subsidiaries and/or third-party contractors. Also as used herein, The Hartford provides insurance or claim administration services to my employer's employee welfare benefit plan(s).

# Activities of Daily Living (ADL's) Questionnaire



Your Name:	Job Title:
Claim Number:	Policy Number:

## I. Continence

1. Can you identify the need to go to the bathroom?  Yes  No
2. Can you identify the need in time to make it safely to the bathroom?  Yes  No
3. Do you wear any protective clothing?  Yes  No If "Yes," please describe: \_\_\_\_\_
4. Are you able to change this protective clothing as needed?  Yes  No If "Yes,"  with assistance or  without assistance
5. Do you need, or use any special equipment in the bathroom? (Examples: Raised toilet seat, bedside commode, grab bars along toilet? )  Yes  No If "Yes," please list: \_\_\_\_\_  
\_\_\_\_\_
6. Does someone help you to get on or off the toilet?  Yes  No

## II. Dressing

1. Are you able to dress yourself?  Yes  No Can you undress yourself?  Yes  No
2. Please describe how your illness/injury has impacted your ability to dress (Examples: Do you need any help with zippers, buttons, or snaps? Help with shoes or socks? Hosiery?) \_\_\_\_\_  
\_\_\_\_\_
3. If braces or artificial limbs are used, are you able to put on your brace/adaptive equipment by yourself, or do you need help?  Yes  No If "Yes," what type of help do you need? \_\_\_\_\_  
\_\_\_\_\_
4. Are you able to put on blouses/shirts and pants without help?  Yes  No
5. If you need help dressing or taking off your clothes, please describe what someone else helps you to do and how. \_\_\_\_\_  
\_\_\_\_\_
6. If any equipment is used for dressing or undressing, please describe it: \_\_\_\_\_  
\_\_\_\_\_

## III. Bathing

1. Can you take a shower or bath by yourself?  Yes  No  
If you need assistance, please describe the type of help you need (Examples: washing, drying) \_\_\_\_\_  
\_\_\_\_\_
2. Are you able to get into and out of the tub or shower by yourself?  Yes  No If "No," what type of help do you need? \_\_\_\_\_  
\_\_\_\_\_
3. Please describe any special equipment or devices you use to help you with your baths or showers? (Examples: grab bar, shower chair, hand-held showerhead): \_\_\_\_\_  
\_\_\_\_\_

**IV. Eating**

1. Do you need any help getting food into your body once it has been prepared for you?  Yes  No
2. Do you need help getting food from the plate to your mouth?  Yes  No
3. Does someone have to remind or encourage you to eat?  Yes  No
4. Do you have any trouble swallowing food?  Yes  No
5. Do you use any equipment to help you to eat?  Yes  No If "Yes, please describe (Examples: weighted spoon or fork, high rimmed/lipped plate, sipping cup): \_\_\_\_\_
6. If someone helps you during your meals, please explain the type of help they provide (Examples: cutting food, guiding spoon, encouragement) : \_\_\_\_\_  
\_\_\_\_\_

**V. Transferring to/from bed, chair**

1. Do you need any help to get in or out of bed?  Yes  No
2. Can you change position while lying in bed without help?  Yes  No
3. Can you move from the bed to a chair by yourself?  Yes  No
4. Can you stand up by yourself after lying in bed?  Yes  No
5. Can you stand up by yourself after sitting in a chair?  Yes  No
6. If you need help to do any of these things, please describe the type or extent of help you need, including any equipment that you use (Examples: Hoyer lift, cane, walker, crutches): \_\_\_\_\_  
\_\_\_\_\_

**VI. Mobility**

1. Can you walk by yourself from one room to another in your home?  Yes  No
2. Can you walk independently outdoors?  Yes  No
3. If you need help to do these things, please describe the type and extent of help that you need, including any equipment that you use both indoors and outside. (Examples: another person supporting you, walker, cane, crutches, wheelchair or motorized scooter) \_\_\_\_\_  
\_\_\_\_\_

**Signature**

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The statements contained in this Ability Plus Benefit Questionnaire are true and complete to the best of my knowledge and belief.

Claimant Signature \_\_\_\_\_ Date \_\_\_\_\_

Claimant Address \_\_\_\_\_ Telephone Number: (    ) \_\_\_\_\_

**PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR ANOTHER DOCUMENT THAT VERIFIES YOUR DATE OF BIRTH, UNLESS IT WAS PREVIOUSLY PROVIDED TO US.**

## WORK AND EDUCATIONAL HISTORY



Claimant's Name	Social Security Number	Date
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### Educational Background

Are you a High School Graduate?

Yes    If "Yes," check one:    Diploma    GED    Enter the Date completed: \_\_\_\_\_

No    If "No," enter the Highest Grade Completed: \_\_\_\_\_ and Date completed: \_\_\_\_\_

### Other Education / Training (please include any current programs):

College / School / Institute / Facility		City / State
Dates Attended	Degree Earned and the Year Completed	Major(s), Minor(s), Certificate, License
College / School / Institute / Facility		City / State
Dates Attended	Degree Earned and the Year Completed	Major(s), Minor(s), Certificate, License
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Dates Attended	Degree Earned and the Year Completed	Major(s), Minor(s), Certificate, License

**For additional education or specialized training, attach a separate sheet with the above information.**

Current Occupational Certificate / License with expiration date (e.g., CDL, forklift) \_\_\_\_\_

Computer skills / programs used?    Word    Excel    PowerPoint    Access    10-key  
 E-Mail    Internet    List other programs used: \_\_\_\_\_

Which is your Dominant Hand?    Right    Left    Ambidextrous (use both equally)

Were you in the Military?    Yes    No    Dates served: \_\_\_\_\_ to \_\_\_\_\_

If "Yes," provide Branch, Rank, and Specialty \_\_\_\_\_

What is your Primary (or first) Language? \_\_\_\_\_

List all other languages that you speak and / or write fluently \_\_\_\_\_

### Volunteer Activities / Community Work / Hobbies

Organization / Group / Club	Dates	Duties / Responsibilities / Equipment Used

**For additional activities, attach a separate sheet with the above information.**

### Work Experience

Please start with your most recent Employer and list all Jobs for the past 15 years in date order.  
If you held **different** jobs with the *same* employer, please list them separately with dates in each position.

Dates of Employment: From _____ To _____		Name of Employer:	
City / State		Type of industry	
Job title (s)			
Did you supervise anyone? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," how many? _____			
Tools / Equipment used			
Duties / Responsibilities			

Dates of Employment: From _____ To _____		Name of Employer:	
City / State		Type of industry	
Job title (s)			
Did you supervise anyone? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," how many? _____			
Tools / Equipment used			
Duties / Responsibilities			

Dates of Employment: From _____ To _____		Name of Employer:	
City / State		Type of industry	
Job title (s)			
Did you supervise anyone? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," how many? _____			
Tools / Equipment used			
Duties / Responsibilities			

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**Signature**

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**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."**

**For residents of Louisiana:** 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 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 Puerto Rico:** Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**For residents of Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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

Claimant Signature	Date
Claimant Address (Street, City, State & Zip Code)	Telephone Number ( )

**PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE OR ANOTHER DOCUMENT THAT VERIFIES YOUR DATE OF BIRTH, UNLESS IT WAS PREVIOUSLY PROVIDED TO US.**

HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY



**ATTENDING PHYSICIAN'S STATEMENT OF FUNCTIONALITY**

To be completed by the Employee

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

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 - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company)

Patient's condition is a result of:  Sickness  Injury  Pregnancy

If pregnancy, What is the expected delivery date? \_\_\_\_\_

Is condition due to illness or injury that is work related?  Yes  No

**DIAGNOSIS**

Primary diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Secondary diagnosis(es): \_\_\_\_\_ ICD-9 Code(s): \_\_\_\_\_

Current Subjective symptoms: \_\_\_\_\_

Physical Examination Findings: \_\_\_\_\_

Blood pressure: \_\_\_\_\_ Date BP taken: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Current Pertinent Test Results (list all results, or enclose test result reports):**

Test: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Test: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

Current Medications, Dosage and Frequency: \_\_\_\_\_

**TREATMENT PLAN**

Current Treatment Plan: \_\_\_\_\_

What is the Frequency / Duration of Treatment? \_\_\_\_\_ Date(s) of Treatment: \_\_\_\_\_

First Office Visit for this condition: \_\_\_\_\_ Last Office Visit: \_\_\_\_\_ Next Scheduled Office Visit \_\_\_\_\_

Date patient reported stopping work: \_\_\_\_\_ Date of disability: \_\_\_\_\_ Expected return to work date: \_\_\_\_\_

Has patient been referred to any other physician?  Yes  No If "Yes," Date of Referral(s): \_\_\_\_\_

Referral Physician Name: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_ Specialty: \_\_\_\_\_

Has surgery been performed since last report?  Yes  No Is surgery planned?  Yes  No

If "Yes," on what date(s): \_\_\_\_\_ Procedure(s): \_\_\_\_\_ CPT Code: \_\_\_\_\_

Was patient hospitalized since last report?  Yes  No If "Yes," Hospital Name: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

**FUNCTIONAL CAPABILITIES**

Please complete the applicable portion of this section based on your most recent assessment:

In a general workplace environment the patient is able to:

	Sit	Stand	Walk
Number of hours at a time			
Total hours/day			

Please check the frequency with which the patient can perform the following activities:

R = Right      L = Left      B = Bilateral		Never	Occasionally (1-33%)	Frequently (34-67%)	No Restrictions	Not Applicable
Lift / carry 1 to 10 lbs.		R L B	R L B	R L B	R L B	
Lift / carry 11 to 20 lbs.		R L B	R L B	R L B	R L B	
Lift / carry 21 to 50 lbs.		R L B	R L B	R L B	R L B	
Lift / carry 51 to 100 lbs.		R L B	R L B	R L B	R L B	
Lift / carry over 100 lbs.		R L B	R L B	R L B	R L B	
Bending at waist						
Kneeling / crouching						
Driving						
Reaching only (not load-bearing)	Above shoulder	R L B	R L B	R L B	R L B	
	At waist / desk level	R L B	R L B	R L B	R L B	
	Below waist / desk level	R L B	R L B	R L B	R L B	
Fingering / handling		R L B	R L B	R L B	R L B	

Is the patient's vision impaired?  Yes  No If "Yes," please describe the extent of the impairment \_\_\_\_\_

Best corrected visual acuity: R \_\_\_\_\_ L \_\_\_\_\_ Hand dominance:  R  L

Does the patient have a psychiatric / cognitive impairment?  Yes  No If "Yes," please describe the extent of the impairment and its etiology: \_\_\_\_\_

Expected duration of any current restriction(s) or limitation(s) listed above: \_\_\_\_\_

Do you believe the patient is competent to endorse checks and direct the use of the proceeds?  Yes  No

Can the patient participate in vocational rehabilitation services (this may include worksite accommodations, identifying alternative work, and or retraining assistance)?  Yes  No If "No," anticipated date they can participate: \_\_\_\_\_

**PHYSICIAN INFORMATION**

Provider's Name: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

Degree: \_\_\_\_\_ Specialty: \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

License Number: \_\_\_\_\_ Social Security Number or EIN \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_