GROUP BENEFITS

Dear TWU Member,

The ability to earn an income is our greatest asset – an asset so valuable, we ought to insure it.

Transport Workers Union of America (TWU) is offering Long-term Disability insurance from The Hartford to help ensure that if the unexpected happens, you and/or your family can have a financial safety net to fall back on. And because this coverage is available at a group rate, it costs less than you might think. You can have payments automatically deducted from your paycheck. That means no bills and no checks to write.

Did you know that over 90% of disabling accidents and injuries happen outside the workplace and therefore are not covered by worker's compensation?[1] When you consider that a disabling injury occurs every one second, it's protection you won't want to be without.[2]

The information in this package can help you decide whether coverage is right for you. Take the time to read it carefully and consider your options.

How do you enroll?

1) Complete all sections of the enclosed "Long-term Disability Benefits Enrollment Form" and return it to your Local Union Representative.

2) Have your Union Representative complete the Employer sections of the "Personal Health Application" (PHA).

3) Complete the remaining sections of the PHA (Employee and Medical Information) and submit the complete form directly to The Hartford at the following address:

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

You'll be notified by mail when a final decision is made on your application. If coverage is approved your payroll deductions will begin the month following the date of your approval.

If you have questions on completing the PHA or questions on the status of your application once you submit it, you may contact The Hartford Medical Underwriting department at 1-800-331-7234.

[1] National Safety Council, *Injury Facts,* 2008 edition.
[2] Council for Disability Awareness. *The 2008 CDA Long-Term Disability Claims Review.* Available: http://www.disabilitycanhappen.org/surveys/CDA_LTD_Claims_Survey_2008.asp. September 25, 2009.

Underwritten by Hartford Life and Accident Insurance Company. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

XXXX-NS 01/10 ©2010 The Hartford, Hartford, CT 06115

Group Benefits from The Hartford

Income Protection Benefits

Transport Workers Union of America
Long-Term Disability Benefits Enrollment Form

Information About You

Name:	**Employee ID Number:**
Home Address:	**Date of Birth:**
City: State: Zip:	**Home Phone Number:**
Local Union Number:	**Date of Hire:**

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **check** your election below.
- **Step 2:** Please **sign, date and return** this form to your Local Union Representative.

Voluntary Long Term Disability Insurance

Voluntary Long Term Disability Insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period. If you declined coverage as a new hire, you will be considered a "late entrant". Late entrants must show evidence of insurability by completing a *Personal Health Application*. You may be responsible for physical exams or other associated costs if they are required. You must be approved by The Hartford to receive coverage.

For rate and cost information, please refer to the rate sheet provided with this form.

☐ I elect to **enroll** in Long Term Disability coverage.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Disability insurance coverage described in the Benefit Fact Sheets and offered through Transport Workers Union of America.

I understand and agree that if I declined coverage as a new hire, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer.

Signed ______________________________ Date ______________________________

Underwritten by Hartford Life And Accident Insurance Company. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

Expertise without equal.
Benefits without burden.

Group Benefits from The Hartford

Income Protection

Voluntary Long Term Disability Insurance

Benefit Fact Sheet for:

Transport Workers Union of America

Eligibility	You are eligible for coverage if you are an active full time or part time Member of TWU of America, AFL-CIO and employed by American Airlines or Allied Fueling. Active full time Members must work at least 30 hours per week on a regularly scheduled basis. Active part time Members must work at least 20 hours per week on a regularly scheduled basis.
Coverage Effective Date and Late Entrants	Coverage goes into effect subject to the terms and conditions of the policy. You must be Actively at Work with your employer on the day your coverage takes effect. If you declined coverage as a new hire you will be considered a "late entrant". Late entrants must show evidence of insurability by completing a Personal Health Application. You may be responsible for physical exams or other associated costs if they are required. You must be approved by The Hartford to receive coverage.
Recalled Members	Members who are recalled more than two years from original lay off date will be treated as new hires for benefits purposes. Members recalled less than two years from original lay off date will resume any benefits in place prior to lay off. Those recalled within two years who did not previously have LTD coverage will be considered late entrants.
Benefit Percentage & Maximum Monthly Benefit	**Full Time Members:** You may purchase coverage that pays you a benefit of the lesser of 50% of your Earnings or 70% with Offsets, to a maximum monthly benefit of $4,000 per month. This plan includes a minimum benefit of the greater of: 10% of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits or $100 per month. **Part Time Members:** You may purchase coverage that pays you a benefit of 50% of your Earnings or to a maximum monthly benefit of $500 per month. This plan includes a minimum benefit of the greater of: 10% of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits or $100 per month.
Other Income Benefits	Your benefit payments **will be reduced** by other income you receive or are eligible to receive due to your disability, including but not limited to: • Social Security Disability Insurance (please see next section for exceptions) • Worker's Compensation • Other employer-based Insurance coverage you may have • Unemployment benefits • Settlements or judgments for income loss • Retirement benefits that TWU fully or partially pays for (such as a pension plan.)
Elimination Period	You must be disabled for 180 days before benefits may be payable.
Benefit Duration	For as long as you remain disabled, or until you reach your Social Security Normal Retirement Age (as stated in the 1983 revision of the United States Social Security Act.), whichever is sooner. If your disability occurs at age 65 or above, your payments may be reduced.

Underwritten by Hartford Life And Accident Insurance Company. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

Expertise without equal.
Benefits without burden.

Deferred LTD Benefit	The Deferred LTD Benefit accrues credits, similar to a pension benefit, when you are disabled and receiving benefits under the Long Term Disability plan. This benefit is payable if you have accrued credit whether or not you remain employed. Please refer to the policy booklet for complete details.
Other Income Benefits	Your benefit payments **will not be reduced** by certain kinds of other income, including but not limited to: • Retirement benefits if you were already receiving them before you became disabled • Retirement benefits that are funded by your after-tax contributions • The portion of your Long -Term Disability payment that you place in an IRS-approved account to fund your future retirement. • Your personal savings, investments, IRAs or Keoghs • Profit-sharing • Most individual disability policies • Social Security increases
Definition of Disability	Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical conditions covered by the insurance, and as a result, your current monthly earnings are 80% or less than your pre-disability earnings. Once you have been disabled for 24 months, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are 80% or less than your pre-disability earnings.
Definition of Earnings	Earnings are defined as Base Monthly Earnings.
Survivor Income Benefit	The Survivor Income Benefit pays a 3 months, lump sum benefit to your surviving spouse (or your children in equal shares if there is no surviving spouse) if you die while receiving LTD benefits. If there are no survivors, no benefits will be paid.
Mental Illness, Alcoholism and Substance Abuse	• You can receive benefit payments for Long-Term Disabilities resulting from mental illness, alcoholism and substance abuse for a total of 24 months for all such disabilities during your lifetime. • Any period of time that you are confined in a hospital or other facility licensed to provide medical care for mental illness, alcoholism and substance abuse does not count toward the 24 months lifetime limit.
Pre-Existing Conditions	Your Insurance limits the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your policy, you will be covered for a disability due to that condition only if: • You have not received treatment for your condition for the length of time specified in the contract before the effective date of your Insurance, or • You have been insured under this coverage for length of time specified in the contract prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or • You have already satisfied the pre-existing condition requirement of your previous insurer.

Limitations and Exclusions

Benefits are not payable for disabilities resulting from any of the following; war or act of war (declared or not) or, the commission or attempt to commit a felony. In addition, your plan may exclude a disability caused or contributed to by an intentionally self-inflicted injury. Benefits are not payable if you are not under the regular care of a physician.

This Benefit Fact Sheet explains the general purposes of the Insurance described, but in no way change or affect the policy as actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of Insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with your other important papers.

Underwritten by Hartford Life And Accident Insurance Company. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

Group Benefits from The Hartford

Income Protection Benefits

Transport Workers Union of America
Long Term Disability Benefit Cost Sheet

Instructions

- **Step 1:** Please locate your group description.
- **Step 2:** Use the rates and costs provided to estimate your Monthly or Weekly Long Term Disability cost.

GROUP 1 DESCRIPTION: Full time members at AA except Flight Dispatchers who are not eligible for the disability pension ("not eligible" means under age 50 or less than 15 years of credited experience)

GROUP 1 RATE: $0.56 per $100 Monthly Covered Earnings for first $1,250 of earnings plus $1.16 per $100 Monthly Covered Earnings above $1,250

GROUP 1 SAMPLE COSTS

ANNUAL INCOME	$20,000	$30,000	$40,000	$50,000	$60,000
MONTHLY COST	$11.83	$21.50	$31.17	$40.83	$50.50
WEEKLY COST	$2.73	$4.96	$7.19	$9.42	$11.65

GROUP 2 DESCRIPTION: Full time members at AA except Flight Dispatchers who are eligible for the disability pension ("eligible" means at least age 50 with at least 15 years of credited experience)

GROUP 2 RATE: $3.52 per employee per month for first $1,250 of earnings plus $0.59 per $100 Monthly Covered Earnings above $1,250

GROUP 2 SAMPLE COSTS

ANNUAL INCOME	$20,000	$30,000	$40,000	$50,000	$60,000
MONTHLY COST	$5.98	$10.90	$15.81	$20.73	$25.65
WEEKLY COST	$1.38	$2.51	$3.65	$4.78	$5.92

GROUP 3 DESCRIPTION: Full time AA Flight Dispatchers

GROUP 3 RATE: $0.47 per $100 Monthly Covered Earnings for employees under age 50, and $0.38 per $100 Monthly Covered Earnings for employees age 50 and above

GROUP 3 SAMPLE COSTS – Under age 50

ANNUAL INCOME	$20,000	$30,000	$40,000	$50,000	$60,000
MONTHLY COST	$7.83	$11.75	$15.67	$19.58	$23.50
WEEKLY COST	$1.81	$2.71	$3.62	$4.52	$5.42

Underwritten by Hartford Life and Accident Insurance Company. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.
Expertise without equal.
Benefits without burden.

GROUP 3 SAMPLE COSTS – Age 50 and above

ANNUAL INCOME	$20,000	$30,000	$40,000	$50,000	$60,000
MONTHLY COST	$6.33	$9.50	$12.67	$15.83	$19.00
WEEKLY COST	$1.46	$2.19	$2.92	$3.65	$4.38

GROUP 4 DESCRIPTION: All Part time AA Members

GROUP 4 RATE: $3.56 per employee per month

GROUP 4 SAMPLE COSTS

ANNUAL INCOME	$20,000	$30,000	$40,000	$50,000	$60,000
MONTHLY COST	$3.56	$3.56	$3.56	$3.56	$3.56
WEEKLY COST	$0.82	$0.82	$0.82	$0.82	$0.82

GROUP 5 DESCRIPTION: Full time at Allied Fueling (not eligible for the deferred LTD payment benefit)

GROUP 5 RATE: $0.28 per $100 Monthly Covered Earnings for first $1,250 of earnings plus $0.59 per $100 Monthly Covered Earnings above $1,250

GROUP 5 SAMPLE COSTS

ANNUAL INCOME	$20,000	$30,000	$40,000	$50,000	$60,000
MONTHLY COST	$5.96	$10.88	$15.79	$20.71	$25.63
WEEKLY COST	$1.38	$2.51	$3.64	$4.78	$5.91

GROUP 6 DESCRIPTION: Full time American Eagle Members

GROUP 6 RATE: $0.40 per $100 Monthly Covered Earnings

GROUP 6 SAMPLE COSTS

ANNUAL INCOME	$20,000	$30,000	$40,000	$50,000	$60,000
MONTHLY COST	$6.67	$10.00	$13.33	$16.67	$20.00
WEEKLY COST	$1.54	$2.31	$3.08	$3.85	$4.62

GROUP 7 DESCRIPTION: Part time American Eagle Flight Dispatchers

GROUP 7 RATE: $2.97 per employee per month

GROUP 7 SAMPLE COSTS

ANNUAL INCOME	$20,000	$30,000	$40,000	$50,000	$60,000
MONTHLY COST	$2.97	$2.97	$2.97	$2.97	$2.97
WEEKLY COST	$0.69	$0.69	$0.69	$0.69	$0.69

Underwritten by Hartford Life and Accident Insurance Company. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

PERSONAL HEALTH APPLICATION

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Section 1 has been pre-populated for you. Please, completely fill out **Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1: Employer Details

PLEASE PRINT CLEARLY

Employer Name: **Transport Workers Union of America**	Policy Number: **395086**
Division *(if applicable)*: **TWU Local 568**	
Employer Mailing Address (Street, City, State, Zip Code): **5395 N. W. 36th Street, Miami Springs, FL 33166**	
Benefits Contact Name (First, Last): **Maritza Blanco**	
Benefits Contact Email Address: **Maritza568@bellsouth.net**	Benefits Contact Phone: **(305) 874-2788**

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

PLEASE PRINT CLEARLY

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 The Hartford.

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 Guarantee Issue (GI)**) in **Current Coverage**. 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 will be responsible for all fees incurred during the medical underwriting process.

		Current Coverage (including GI Amount)	Additional Coverage Requested	Total Coverage Amount
	Disability Insurance Coverage	*Enter all amounts as dollars or as percentage of Base Annual Earnings*		
☐	Long Term Disability			

** Guarantee Issue (GI) is the maximum amount of coverage, as defined in the contract with The Hartford, which does not require evidence of good health.

Employees: Please complete pages 2 thru 5. It should take you about 10 minutes to complete this form.

The Hartford® is The 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.

Applicant Section: Please answer all questions on this page completely and accurately and certify your answers on page 4.
Leaving information blank will result in delays and may result in your file being closed.

Section 3: Employee Information

PLEASE PRINT CLEARLY

First Name:		Last Name:	Social Security # : - -	
Home Mailing Address (Street, Apt. #):			City:	
State:	Zip Code:	Employer: **Transport Workers Union of America #395086 (TWU Local 568)**		
Daytime Phone:		Evening Phone:	Height: ___Ft. ___In.	Weight:________ lbs.
Gender: ☐ M ☐ F	Date of Birth:	Email Address:		

Section 4– Medical Information *(To be completed by the applicant)*

If you can answer ***Yes*** to any of the Questions below, check the appropriate box and provide **additional details in Section 5.** If you are a **resident of one of the following states:** Connecticut, Florida, Kentucky, Maine, Maryland, Minnesota, New York, North Carolina, Vermont, or Wisconsin then please go to the State Variable Question section on page 3 and answer or review the appropriate question for your state. **After you have read that information, proceed with completing this section**.

Question	
1. 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
2. Within 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 under the influence of drugs or alcohol?	☐ Employee
3. Are you currently undergoing any diagnostic testing for symptoms without a final diagnosis or resolution?	☐ Employee
4. Are you currently pregnant? If yes, what was your pre-pregnancy weight?_________ lbs.	☐ Employee
5. 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), AIDS-Related Complex (ARC), or any other immune deficiency disorder?	☐ Employee

6. 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		**Employee**
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	☐

The Hartford® is The 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.

Employee: First Name ______________________________ Last Name ____

Section 4 Continued: State Variable Questions

For residents of Connecticut, Florida, Kentucky, Maine, Maryland, Minnesota, New York, North Carolina, Vermont, and Wisconsin review or answer, where applicable, the question listed below instead of the corresponding question listed in the Medical Information section on **page 2**. Any "Yes" responses can be explained in the Additional Details section of this form. Once you have reviewed/answered these questions, please return to **Section 4** and proceed with completing the rest of the form.

Information to be Reviewed

Florida, Kentucky, and Maryland Residents- Please review this question prior to answering Question 6 in the Medical Information Section on Page 2:
Question 6: During the past 5 years have you been diagnosed with, treated for, or treated with any of the following conditions or treatments listed below? **Please check all of the conditions on page 2 that apply.**

Maine Residents- Please review this statement prior to answering the medical questions in Section 4 on Page 2:
You are not required to disclose whether you have been tested for HIV, if you have not developed symptoms of the disease AIDS or ARC, in your answer to any of the questions in the Medical Information section.

Minnesota Residents- Please review this statement prior to answering the medical questions in Section 4 on Page 2:
You need not disclose an HIV (aids virus) test which was administered: (1) to a criminal offender or criminal victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services.
Please review this question prior to answering Question 6 in the Medical Information Section on Page 2:
Question 6: During the past 5 years have you been diagnosed by a physician with, treated for, or treated with any of the following conditions or treatments listed below? **Please check all of the conditions on page 2 that apply.**

Questions to be Answered

Connecticut and Minnesota Residents: Do not answer Question 2 in the Medical Information section. Answer the following question below.
Question 2: Within 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 convicted of operating a motor vehicle under the influence of drugs or alcohol? ☐ **Employee**

Florida residents: Do not answer Question 5 in the Medical Information section. Answer the following question below.
Question 5: Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or had unexplained weight loss or enlarged lymph nodes?
☐ **Employee**

New York Residents: Do not answer Question 5 in the Medical Information section. Answer the following question below.
Question 5: 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), AIDS-Related Complex (ARC), or any other immune deficiency disorder excluding HIV?
☐ **Employee**

North Carolina Residents: Do not answer Question 5 in the Medical Information section. Answer the following question below.
Question 5: Have you ever been diagnosed 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? AIDS Related Complex (ARC) is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.
☐ **Employee**

Vermont Residents: Do not answer Questions 3 or 5 in the Medical Information section. Answer the following questions below.
Question 3: Are you currently undergoing any diagnostic testing (excluding prior HIV related testing) for symptoms without a final diagnosis or resolution? ☐ **Employee**
Question 5: Have you been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician?
☐ **Employee**

Wisconsin Residents: Do not answer Question 3 in the Medical Information section. Answer the following question below.
Question 3: Are you currently undergoing any diagnostic testing, excluding AIDS or HIV tests, for symptoms without a final diagnosis or resolution? ☐ **Employee**

Please proceed with completing the rest of the medical questions on Page 2 once you have completed/reviewed this page.

The Hartford® is The 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.

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. The Hartford may contact you for additional or missing information.

Question # or Condition	Medications/ Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name, Address, and Phone #

Section 6: Health Question Certification Statement *(To be completed by the applicant)*

By checking this box: ☐ **Employee**

I hereby certify that I have reviewed each of the above questions and conditions.
I also certify that I have checked all of the questions and conditions that apply to my health history.

Section 7: Authorization *(To be reviewed by the applicant)*

New York Residents: I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford. I authorize The Hartford to give information about me to: its reinsurer(s); the Medical Information Bureau, Inc.; any other insurance company to whom I may apply for Life or Health Insurance; or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application; or as required 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.

Residents of All States Except New York: I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford. I authorize The Hartford to give information about me to: its reinsurer(s); the Medical Information Bureau, Inc.; any other insurance company to whom I may apply for Life or Health Insurance; or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application; or as required 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 effective date of my coverage or, if no coverage has been issued, one (1) year 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.

Additional Language for Maine Residents: This authorization excludes disclosure of the result of a test for HIV if the applicant has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS or ARC. I understand that my failure to sign this authorization may impair the ability of The Hartford to process this application or evaluate claims and may be a basis for denying this application or a claim for benefits.

Additional Language for Minnesota Residents: This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or criminal victim as a result of a crime that was reported to the police; (2) to a patient who received the services of Emergency Medical Services personnel at a hospital or medical care facility; or (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "Emergency Medical Personnel" includes individuals employed to provide pre-hospital emergency services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and would qualify for immunity under the Good Samaritan Law.

Employee: First Name ______________________________ **Last Name** ____

Section 8: Certification (*To be reviewed by the applicant*)

Residents of All States: I hereby certify (**"represent" for Kansas residents)** that all statements and answers contained herein, are full, complete, and true to the best of my knowledge and belief.

Residents of All States Except New York: I also understand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the coverage, within the contestable period if such misrepresentation materially affects acceptance of the risk. This information may be used by The Hartford for plan administration purposes to decide if the person(s) is/are eligible for coverage.

I understand that coverage will not become effective until The Hartford grants it's underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

I agree that this document and all its contents shall form a part of my request for group benefits.

Section 9: Fraud Statement *(To be completed by the applicant)*

Residents of All States Except California, Pennsylvania, and New York: 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.

California Residents: 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**.**

Pennsylvania Residents: 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.

New York Residents: 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 The Hartford 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.

___________________________________ ____/____/____

Employee's Signature
or Legal Representative/ Relationship to
Employee **(Required)**

Date Signed

Please return the completed Employer and Employee sections to:
The Hartford, Medical Underwriting
P.O. Box 2999
Hartford, CT 06104-2999

After submitting this application, you can check your status on line at **www.TheHartfordAtWork.com.**

If you have any questions or concerns, please call The Hartford Customer Service Department toll-free at
1-800-331-7234, Monday through Friday, 8:00 a.m. to 6:00 p.m., Eastern Time, or email us at medical.uw@hartfordlife.com**.**

The Hartford® is The 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.