

SERFF Tracking Number: HARL-127648171 State: Arkansas  
Filing Company: Hartford Life and Accident Insurance Company State Tracking Number: 50194  
Company Tracking Number: GBD\_CI\_GCF\_PHA FILING\_2011\_11  
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness  
Limited Benefit  
Product Name: GCF\_AR\_HLA\_CI\_PA-9475 (CW)(HLA)\_2011\_PHA Filing  
Project Name/Number: /2971

## Filing at a Glance

Company: Hartford Life and Accident Insurance Company

Product Name: GCF\_AR\_HLA\_CI\_PA-9475 SERFF Tr Num: HARL-127648171 State: Arkansas  
(CW)(HLA)\_2011\_PHA Filing

TOI: H07G Group Health - Specified Disease - SERFF Status: Closed-Approved- State Tr Num: 50194  
Limited Benefit Closed

Sub-TOI: H07G.001 Critical Illness Co Tr Num: GBD\_CI\_GCF\_PHA State Status: Approved-Closed  
FILING\_2011\_11

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Lori Minchoff, Yolanda  
Topps, Susan Steiner, Christine  
Sawyer

Disposition Date: 11/07/2011

Date Submitted: 11/04/2011

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile:

Project Number: 2971

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 11/07/2011

State Status Changed: 11/07/2011

Deemer Date:

Created By: Susan Steiner

Submitted By: Lori Minchoff

Corresponding Filing Tracking Number:

Filing Description:

RE: FORM NAME FORM NUMBER

Evidence of Insurability PA-9475 (CW)(HLA)

Extended Evidence of Insurability PA-9475 EEOI (CW)(HLA)

Joint/Musculoskeletal Questionnaire PA-9475 JOIMUS (CW)(HLA)

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Psychological Questionnaire PA-9475 PSY (CW)(HLA)  
Respiratory Questionnaire PA-9475 RESP (CW)(HLA)

We are submitting the enclosed Evidence of Insurability application forms for your review and approval on a general-use basis for applicants for group critical illness insurance. These forms have been redesigned to enhance underwriting consistency, usability, and readability. They may be used for any combination of group critical illness insurance, group disability income (including group short-term disability and group long-term disability) insurance, or group term life insurance that is selected by an applicant. Our domiciliary state of Connecticut granted approval for out-of-state filings on September 29, 2011.

These forms are new and do not replace any forms on file with your Department. These forms are intended for use by employees/members and dependents of:

1. eligible employer-employee groups;
  2. eligible labor union groups; and
  3. eligible trust groups sponsored by employers,
- as defined and allowed by the laws and regulations of your state. These forms will be used in conjunction with any of our approved group life or group disability income insurance policies that require medical underwriting

Our Critical Illness product is currently in development as a cash fixed indemnity benefit plan. This application will not be used for Critical Illness purposes until the policy, certificate and rates are filed and approved by your state insurance department

We are licensed to do business in two different underwriting companies. Policies issued in Arkansas, or any state other than NY, are underwritten by Hartford Life and Accident Insurance Company. All applicants from Arkansas who need to submit evidence of insurability for coverage under those policies will complete this Hartford Life and Accident Insurance Company application, once it is approved by your Department. Policies issued in New York are underwritten by Hartford Life Insurance Company. All applicants from Arkansas who need to submit evidence of insurability for coverage under a New York issued policy, will receive a Hartford Life Insurance Company version of this application, which contains identical language, even though the underwriting company references throughout the form are different.

The application form is identified by a form number which will always appear on the bottom left hand corner of the first page, and may appear on any subsequent page. Although there are identification numbers in the lower right hand corner of each module or section of the forms, these numbers are only for your ease in reviewing. These numbers will not appear on the final forms when they are presented to our customers and their employees and dependents. This is not a modular filing. Were we ever to re-file these forms in the future, we would present these forms in their entirety with

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that re-filing.

All variable material is indicated by brackets. We reserve the right to alter any component of the forms allowed by the laws and regulations of your state.

We intend to distribute the application through different channels, based on consistently applied case size requirements and at the request of our policyholders. They will be created with the approved language and within the variability of this filing.

1. Paper applications to be completed by the applicant and mailed to us.
2. Paper applications that may be partially pre-filled with data we have previously received from the policyholder. Applicants are asked to confirm that their personal pre-filled data is correct prior to completing and returning the form.
3. Online applications (Adobe Acrobat PDF file) that may be partially pre-filled based on data we have previously received from the policyholder. These online applications can be printed out, completed, and mailed to us. These online applications appear exactly as a paper application would, within the terms of the approved variability.
4. Online applications (World Wide Web) that can be completed and transmitted to us electronically. We will present the filed questions on the form in a consistent, e-friendly manner for the applicant, and then present a PDF version of the filed paper application, complete with the applicant's responses prior to the final approval/submission by the applicant. We may repeat or reassemble modules, column headers, questions and/or instructions so that each applicant may be presented with an easily understood online flow of their application, but we will not add any new content without your expressed consent. The applicant will have the ability to print the completed EOI Form as a confirmation after submitting the document to us online. Our online submission process complies with applicable state and federal e-signature laws. If you have specific requirements for the online use of applications that we have not considered, please provide us with the appropriate citations.
5. Applications that can be completed, in whole or in part, via the telephone. If an applicant submits a signed application that contains missing information, we may obtain that information via telephonic interview using recorded lines. The applicant will be advised that they are on a recorded line, and we will validate the identity of the applicant by asking them for 2 identifiers that we have previously been supplied with. The applicant will be re-advised of fraud and certification requirements from the original form, and that the signature still applies to information provided during the telephonic interview. If the original application was not signed, we will request the missing information over the telephone and mail a letter to the applicant to obtain their signature. These telephone calls are conducted by our internal employees solely for the purpose of obtaining information necessary to underwrite the pertinent coverages. No solicitation of coverage that would require a licensed agent will be conducted by persons making these calls.
6. Updated applications generated directly from our system are similar to the initial application except for the addition of an applicant header containing an underwriting ID code number and some minor administrative details including but not limited to bar codes we will use for processing. Updated applications are issued when:
  - an applicant's signature on the initial Evidence of Insurability application is over 90 days old; or

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- at the end of the underwriting process, the signature on the most recent application or exam is over 180 days old; or
- an initial application was not completed for one or more of the applicants; or
- the initial application is so incomplete or unclear that it is administratively more efficient than attempting to follow up.

Applications may be supplemented with any of the three questionnaires included in this filing. If an applicant indicates a condition on form PA-9475 (CW)(HLA) to which one of the questionnaires applies, that condition will be further investigated. We may obtain the information via telephonic interview using a recorded line or by mailing the questionnaire to the applicant to complete and return to us.

PA-9475 (CW)(HLA) applications for amounts of insurance at or above our defined risk threshold and not denied on original review will be supplemented with the Extended Evidence of Insurability form, which may be produced in two versions to be used by an examination vendor. One version combines the Medical questions and the Physical Exam section. The second version will contain only the Physical Exam section. The vendor representative may draw blood, collect a urine sample, take blood pressure and pulse, and weigh and measure the applicant to provide height and weight according to state prescribed protocols. We may create a version of this form containing only the Medical questions which may be taken over the phone in a telephone interview or sent directly to the Applicant for their direct response back to The Hartford. If the form is returned to us with any unanswered questions, we may call out to the Applicant and ask the unanswered questions over the telephone. The vendor representative may draw blood, collect a urine sample, take blood pressure and pulse, and weigh and measure the applicant to provide height and weight according to state prescribed protocols.

State specific language may be represented in the form in two different ways. If we are issuing a paper application without knowing the states of residence of the potential applicants, we intend to issue one form which contains any required state-specific language for all states. When creating applications where we know the state of residence of the applicant, we may delete all of the state language except for the language that is applicable to that state of residence. In either event, we would use the same form number. If any additional state specific language becomes required for this application during the state approval process, we will add it to the combined states form where appropriate. We will send out final versions of the forms to all states for their information once the process is complete.

We reserve the right to make changes required to comply with Section 508 of the Rehabilitation Act. While the content of the forms will not change, the format may be changed to make the forms accessible for disabled users. We may include accessible instructions to assist the Applicant in the completion of their form.

We are in the process of filing an application for a patent to cover this form and the SOVL process tool. Once the patent is filed, we may add "patent pending" to the paper application and the web page. If the patent is later approved, we may change "patent pending" to the actual US Pat. Number awarded, or if denied, remove "patent pending".

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Thank you in advance for your consideration. We look forward to your approval in the near future.

## Company and Contact

### Filing Contact Information

Susan Steiner, susan.steiner@hartfordlife.com  
 200 Hopmeadow Street 860-843-9598 [Phone]  
 Simsbury, CT 06089

### Filing Company Information

Hartford Life and Accident Insurance Company CoCode: 70815 State of Domicile: Connecticut  
 200 Hopmeadow Street Group Code: 91 Company Type: Life  
 Simsbury, CT 06089 Group Name: State ID Number:  
 (860) 547-5000 ext. [Phone] FEIN Number: 06-0838648

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$250.00  
 Retaliatory? No  
 Fee Explanation: 5 forms @ \$50 per form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Hartford Life and Accident Insurance Company	\$250.00	11/04/2011	53483517

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/07/2011	11/07/2011

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## Disposition

Disposition Date: 11/07/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Flesch Certification-JOIMUS	Approved-Closed	Yes
<b>Supporting Document</b>	Flesch Certification-PSY	Approved-Closed	Yes
<b>Supporting Document</b>	Flesch Certification-RESP	Approved-Closed	Yes
<b>Supporting Document</b>	Flesch Certification-EEOI	Approved-Closed	Yes
<b>Supporting Document</b>	Forms List	Approved-Closed	Yes
<b>Form</b>	Evidence of Insurability	Approved-Closed	Yes
<b>Form</b>	Joint/Musculoskeletal Questionnaire	Approved-Closed	Yes
<b>Form</b>	Psychological Questionnaire	Approved-Closed	Yes
<b>Form</b>	Respiratory Questionnaire	Approved-Closed	Yes
<b>Form</b>	Extended Evidence of Insurability	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: PA-9475 (CW)(HLA)

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/07/2011	PA-9475 (CW)(HLA)	Application/Evidence of Enrollment Insurability Form	Initial		51.200	10.27.11_PA-9475 (CW)(HLA).pdf
Approved-Closed 11/07/2011	PA-9475 (HLA) JOIMUS	Application/Joint/Musculoskeletal Enrollment Questionnaire Form	Initial		51.400	10.27.11_PA-9475 (HLA) JOIMUS.pdf
Approved-Closed 11/07/2011	PA-9475 (HLA) PSY	Application/Psychological Enrollment Questionnaire Form	Initial		57.300	10.27.11_PA-9475 (HLA) PSY.pdf
Approved-Closed 11/07/2011	PA-9475 (HLA) RESP	Application/Respiratory Enrollment Questionnaire Form	Initial		59.600	10.27.11_PA-9475 (HLA) RESP.pdf
Approved-Closed 11/07/2011	PA-9475 EEOI (CW)(HLA)	Application/Extended Evidence Enrollment of Insurability Form	Initial		50.200	10.27.11_PA-9475 EEOI (CW)(HLA).pdf



[EVIDENCE OF INSURABILITY]

[ [Applicant]:  
 Underwriting ID:  
 [Policyholder]:  
 Policy Number(s):]

**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
 [200 Hopmeadow Street, Simsbury, Connecticut 06089]

Form PA-9475 (CW)(HLA)-Banner

<b>[[Contact] Information</b>			
[[Employee]] First Name:		[[Employee]] [Middle Initial]:	[[Employee]] Last Name:
[[Employee]] Mailing Address (Street, Apt. #):			
[[Employee]] City:		[[Employee]] State:	[[Employee]] Zip Code:
[[Employee]] Social Security Number:		[Employee] ID # (if any):	[[Employee]] Date of Birth (mm/dd/yyyy):
[[Employee]] Daytime Phone:]		[[Employee]] Evening Phone:]	
[[Employee]] Email Address:]		[[Employee]] Occupation:]	
[[Employee]] Gender (check one): <input type="checkbox"/> Male <input type="checkbox"/> Female]	[[Employee]] Height (ft./in.):]		[[Employee]] Weight (lbs.):]
[[Spouse]] First Name:]		[[Spouse]] Last Name:]	
[[Spouse]] Mailing Address (Street, Apt. #) [(if different from [Employee] address):]			
[[Spouse]] City:]		[[Spouse]] State:]	[[Spouse]] Zip Code:]
[[Spouse]] Daytime Phone:]		[[Spouse]] Evening Phone:]	
[[Spouse]] Email Address:]		[[Spouse]] Date of Birth (mm/dd/yyyy):]	
[[Spouse]] Gender (check one): <input type="checkbox"/> Male <input type="checkbox"/> Female]	[[Spouse]] Height (ft./in.):]		[[Spouse]] Weight (lbs.):]
[[Child]] First Name:]		[[Child]] Last Name:]	
[[Child]] Mailing Address (Street, Apt. #) [(if different from [Employee] address):]			
[[Child]] City:]		[[Child]] State:]	[[Child]] Zip Code:]
[[Child]] Daytime Phone:]		[[Child]] Evening Phone:]	
[[Child]] Email Address:]		[[Child]] Date of Birth (mm/dd/yyyy):]	
[[Child]] Gender (check one): <input type="checkbox"/> Male <input type="checkbox"/> Female]	[[Child]] Height (ft./in.):]		[[Child]] Weight (lbs.):]

Form PA-9475 (CW)(HLA)-1

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**[[Applicant] Information**

• If there are more than [two] [Applicant], please attach another page with the [Employee] First and Last name, [Applicant] First and Last Name, Relationship to [Employee], Gender, Height, Weight and Date of Birth.  
 [Abbreviations: [Employee] = EE [Spouse] = SP]

First and Last Name	[[EE]]	[[SP]]	Gender (check one)	Height (ft./in.)	Weight (lbs.)	[ Date of Birth (mm/dd/yyyy)]
	[Employee / Spouse / Child Check One]					
[	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female			

[ \_\_\_\_\_ Day Time Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ ]

**[[Medical Information] [( continued)]**

[Each Applicant must answer the following questions to the best of their knowledge and belief, by checking the appropriate "Yes" or "No" box for each question.]  
 [Each Applicant age 15 or older in NC; age 19 or older in AL, DE, NE; age 21 or older in MS; or 18 or older in all other states, is required to answer the following questions to the best of their knowledge and belief, by checking the appropriate "Yes" or "No" box for each question. A Legal Guardian is required to answer the questions for minor children. [If you have more than 1 child, specify which child(ren) the answer applies to on a separate sheet of paper, and please include the Employee's First Name, Middle Initial, and Last Name at the top of the separate sheet of paper.]]  
 [Please answer the following questions to the best of your knowledge and belief. Check a "Yes" or "No" box [for each person applying for coverage,] for each question.]  
 [If you are also applying for Child coverage, a separate application will be mailed to you.]  
 [Abbreviations: [Employee] = EE [Spouse] = SP]

Within the past 5 years, have you used any controlled substances, with the exception of those taken as prescribed by your physician, received medical advice or sought treatment for drug use or alcohol abuse, or been convicted of operating a motor vehicle while under the influence of drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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[Are you currently undergoing any diagnostic testing due to known symptoms, without a final diagnosis or resolution?]  [[For residents of Maine, New York and Vermont:] Are you currently undergoing any diagnostic testing (excluding testing for Human Immunodeficiency Virus (HIV)) due to known symptoms, without a final diagnosis or resolution?]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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[Within the past 5 years, have you been diagnosed with or treated [ by a licensed medical provider] [[(]for residents of Vermont:] by a licensed medical physician[])] for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? [[For residents of Florida:] Within the past 5 years, have you been tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection, or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?]	<input type="checkbox"/> Yes <input type="checkbox"/> No]	<input type="checkbox"/> Yes <input type="checkbox"/> No]
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[Each Applicant must answer the following question to the best of their knowledge and belief, by checking the appropriate "Yes" or "No" box for each condition and/or treatment.]  
 [Please answer the following question to the best of your knowledge and belief. Check a "Yes" or "No" box [for each person applying for coverage,] for each condition and/or treatment.]  
 [Each Applicant age 15 or older in NC; age 19 or older in AL, DE, NE; age 21 or older in MS; or 18 or older in all other states, is required to answer the following question to the best of their knowledge and belief, by checking the appropriate "Yes" or "No" box for each condition and/or treatment. A Legal Guardian is required to answer the questions for minor children. [If you have more than 1 child, specify which child(ren) the answer applies to on a separate sheet of paper, and please include the Employee's First Name, Middle Initial, and Last Name at the top of the separate sheet of paper.]]  
 [Within the past 5 years, have you been diagnosed with, treated for, or had any known symptoms due to any of the following conditions or treatments listed?] [For residents of Florida and Minnesota:] [Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for any of the following conditions or treatments listed?]  
 [Abbreviations: [Employee] = EE [Spouse] = SP]

	[[EE]]	[SP]]		[[EE]]	[SP]]
Heart-Related Surgery or Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease (Do not check "Yes" for [ High Blood Pressure] [and/or] Heart Murmur only)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis (MS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blocked Arteries (including Arteriosclerosis, Atherosclerosis, Aneurysm, or Deep Vein Blood Clot)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Fatigue Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychotic/Personality Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression If yes, please answer the following below:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Failure/Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

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Immune Deficiency Disorder [[([for residents of Maine, New York or Vermont:] [[([excluding Human Immunodeficiency Virus (HIV) tests]])]]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you experience a single episode (a single period of depressed mood)?	<input type="checkbox"/> No	<input type="checkbox"/> No
Cancer (Do not check "Yes" for Basal Cell Carcinoma only)  Date of Diagnosis _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you experience multiple episodes (multiple periods of depressed mood with periods in-between of no depressed mood)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis [(Do not check "Yes" for Hepatitis A only)]	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been hospitalized for depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No]	<input type="checkbox"/> Yes <input type="checkbox"/> No]	Other Mental/ Nervous/ Psychiatric Disorders (including Anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No]	<input type="checkbox"/> Yes <input type="checkbox"/> No]

[[[Employee] Only – [If] you have requested [Short Term Disability (STD) [[[and] [/ or]]] Long Term Disability (LTD)], you are also required to answer the following questions to the best of your knowledge and belief.]			
Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 work days for the same physical, mental, or emotional condition, disability, injury, or sickness? If "Yes", please provide the specific reason causing your lost time from work.  _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently pregnant? If yes: What was your pre-pregnancy weight? _____lbs.			<input type="checkbox"/> Yes <input type="checkbox"/> No]
[[Within the past 5 years, have you been diagnosed with, treated for, or had any known symptoms due to any of the following conditions or treatments listed below?] [[For residents of Florida and Minnesota:] Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for any of the following conditions or treatments listed?]  Please check "Yes" or "No" for each condition.]			
Joint/Ligament Disorder, Injury, or Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Knee Disorder, Injury, or Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis or Osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No]	Back or Neck Disorder, Injury, or Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No]

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[[[If] Critical Illness is being requested, you are also required to answer the following questions to the best of your knowledge and belief. Please check a "Yes" or "No" box [for each person applying for coverage,] for each question.]					
				[ [EE]	[ [SP]]
Have you had, or been recommended to have, any heart-related surgery or major organ transplant surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you increased your high blood pressure medication within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
At any time during the past [ months] to the present, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[[Within the past 5 years, have you been diagnosed with, treated for, or had any known symptoms due to any of the following conditions or treatments listed below?] [Florida and Minnesota residents:] [Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for any of the following conditions or treatments listed?] Please check a "Yes" or "No" box [for each person applying for coverage,] for each question.]					
[Abbreviations: [Employee] = EE [Spouse] = SP]					
	[ [EE]	[ [SP]]		[ [EE]	[ [SP]]
Any disease or disorder of the glands	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Narcolepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disease or disorder of the heart, blood [[[for residents of Maine, New York or Vermont:] [[excluding Human Immunodeficiency Virus (HIV) tests []]] or circulatory system	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transient Ischemic Attack (TIA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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[[CONDITIONS

Acid reflux	Breast disorder
Autism	Breast implants
Elevated cholesterol	Bronchitis
Intestinal ischemia	Bulging disc
Adjustment disorder	Bulimia
Ailment	Bursitis
Alcohol abuse (Maryland residents: Answer "Yes" only if diagnosed with or treated for)	Cancer
Alcohol dependence (Maryland residents: Answer "Yes" only if diagnosed with or treated for)	Cancerous tumors
Alcoholism	Cardio-vascular disorder
Alzheimer's	Carpal tunnel syndrome
Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)	Cataracts
Anemia or other blood conditions	Cellulitis
Aneurysm	Cerebral palsy
Angina	Chemical dependency
Anorexia	Chest pain
Anxiety	Chewing tobacco
Any disease or disorder of the brain or nervous system	Chronic diarrhea
Any disease or disorder of the digestive system	Chronic fatigue syndrome
Any disease or disorder of the glands	Chronic lower respiratory disease
Any disease or disorder of the heart [[([for residents of Maine, New York or Vermont: ] ([excluding Human Immunodeficiency Virus (HIV) tests ])], or circulatory system	Chronic Obstructive Pulmonary Disease (COPD)
Any disease or disorder of the lungs or respiratory system	Cirrhosis
Any disease or disorder of the skin, bones, or joints, including neck or back disorders	Colitis
Arterial disease	Colon polyps
Arteriosclerosis	Coma
Arthritis	Concussion
Asperger's Syndrome	Congenital disease
Asthma	Congenital disorder
Atherosclerosis	Congestive heart failure
Atrial fibrillation	Connective tissue disorder
Attention Deficit Disorder (ADD)	Coronary artery disease
Attention Deficit Hyperactivity Disorder (ADHD)	Crohn's Disease
Autonomic neuropathy	Deafness
Avian flu	Deep vein blood clot
Back disorder	Deep vein thrombosis t
Back pain	Degenerative disc disease
Back strain	Depression (multiple episodes)
Basal cell carcinoma	Depression (single episode)
Bipolar disorder	Diabetes
Bird flu	Dialysis
Birth defect	Disc disorder
Blindness	Discoid lupus
Blocked arteries	Diverticulitis
Blood clot	Dizziness
Blood or circulatory or vascular conditions [[([for residents of Maine, New York or Vermont: ] ([excluding Human Immunodeficiency Virus (HIV) tests ])]	Drug abuse (Maryland residents: Answer "Yes" only if diagnosed with or treated for)
Blood or sugar in urine	Drug dependence (Maryland residents: Answer "Yes" only if diagnosed with or treated for)
Bone spurs	Drug, alcohol, or nicotine use on a regular basis - Indicate amount used daily

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Duodenal ulcer	Herniated disc
Eating disorders	High blood pressure
Emotional disorder	Hip disorder
Emphysema	Hip pain
Endometriosis	Hip replacement
Enlarged lymph nodes or glands	Hives
Epilepsy	Hodgkin's Lymphoma
Epstein Barr virus	Hydrocephalus
Essential hypertension	Hypercholesterolemia
Eyes, ears, nose or throat – chronic	Hypertensive renal disease
Female disorders	Hypothyroidism
Fibroids	Hypocalcemia
Fibromyalgia	Hypothyroidism
Fracture	Immune system [[(]]for residents of Maine, New York or Vermont:]] [[excluding Human Immunodeficiency Virus (HIV) tests ]]]
Gallbladder	Impaired sight or hearing
Gallstones	Inflammatory Bowel Disease (IBD)
Gastritis	Irritable Bowel Syndrome (IBS)
Gastroesophageal Reflux Disease (GERD)	Injury
Genital or reproductive organ problems	Insulin dependent diabetes
Gestational diabetes	Intestinal disorders
Glaucoma	Intestinal
Goiter	Iron deficiency anemia
Gout	Joint disease
Grand mal seizure	Joint disorder
Grave's disease	Joint or ligament disorder, injury or surgery
Growth disorders	Joint pain
Growth hormones	Kidney disease
Hashimoto's thyroiditis	Kidney failure
Head trauma	Kidney stones
Heart ailment	Kidneys, bladder, or urinary tract – chronic
Heart arrhythmia	Knee disorder, injury or surgery
Heart attack	Knee injury
Heart condition	Knee pain
Heart disease	Knee replacement
Heart failure	Left ventricular hypertrophy
Heart murmur	Leukemia
Heart related surgery	Ligament disorder
Heart trouble	Ligaments
Heartburn	Liver
Hemochromatosis	Lou Gehrig's (Amyotrophic Lateral Sclerosis - ALS)
Hemophilia	Low platelet count
Hepatitis A	Lupus
Hepatitis B	Mad cow disease
Hepatitis C	Male disorders
Hepatitis E	Male/female disorders
Hepatitis non-A or B	Manic depressive illness
Hepatitis	Melanoma
Hepatoma	Meniere's disease
Hepatomegaly	Mental or Nervous disorders, including depression
Hereditary motor and sensory neuropathy	Mitral valve prolapse
Hernia	Mitral valve regurgitation

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Mitral valve stenosis	Pulmonary embolism
Multiple myeloma	Pulmonary hypertension
Multiple personality disorder	Pyelonephritis
Multiple Sclerosis (MS)	Rectum
Muscle	Recurrent or chronic sleep disorders/apnea
Muscular Dystrophy (MD)	Reflux
Neck pain	Renal failure
Nephritis	Respiratory problems
Neuritis	Retinopathy
Neuropathy	Myocardial Infarction (MI)
Non-Hodgkin's Lymphoma	Myocarditis
Obsessive Compulsive Disorder (OCD)	Narcolepsy
Organ transplant	Nasal polyps
Osteoarthritis	Neck disorder
Osteomyelitis	Neck injury
Osteopenia	Rheumatic fever
Osteoporosis	Rheumatism
Other mental, nervous or psychiatric disorders	Rheumatoid arthritis
Other mental, nervous or psychiatric disorders (including Anxiety)	Rotator cuff injury
Ovarian cyst	Sarcoidosis
Pancreas	Sarcoma
Pancreatitis	Schizophrenia
Panic attacks	Sciatica
Paralysis	Seasonal Affective Disorder (SAD)
Parkinson's Disease	Seasonal allergy
Pelvic Inflammatory Disease (PID)	Seizure disorder
Pending surgery	Seizure
Peptic ulcer	Septal defect
Pericarditis	Septicemia
Peripheral arterial disease	Severe headaches
Peripheral neuropathy	Shortness of breath
Peripheral vascular disease	Shoulder dislocation
Pernicious anemia	Shoulder injury
Personality disorders	Sickle cell anemia
Petit mal seizure	Sinusitis
Phlebitis	Skin disorders, moles, melanoma, or basal cell carcinoma
Plantar faciitis	Sleep apnea
Pleurisy	Slipped disc
Pneumonia	Spinal cord injury
Pneumonitis	Spinal disorder
Polycystic kidney disease	Spinal stenosis
Polycystic ovary syndrome	Spine
Postpartum depression	Spleen
Post-traumatic stress disorder (PTSD)	Spondylitis
Pregnancy-related hypertension	Spondylosis
Prolapsed bladder	Sprain
Prolapsed uterus	Squamous cell carcinoma
Prostatitis	Stenosis
Protein in urine	Stomach
Psychiatric	Strain
Psychotic disorders	Stroke

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Pulmonary edema	Substance abuse (Maryland residents: Answer "Yes" only if diagnosed with or treated for)
Systemic lupus	Tumor
Tendonitis	Ulcer
Tendons	Ulcerative colitis
Thalassemia	Upper or lower digestive system
Thrombocytopenia	Uterine fibroids
Thrombophlebitis	Uterine prolapse
Thyroid	Varicose veins
Tobacco use	Vascular disease
Tuberculosis (TB)	Von Willebrand's Disease
Tuberculosis	Whiplash ]]

Form PA-9475 (CW)(HLA)-6

**Notice**

To the best of your knowledge and belief, you are required to notify Hartford Life And Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date the coverage is approved.

In order to complete the evaluation of this application, Hartford Life And Accident Insurance Company may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, [and] copies of medical records which you have authorized us to review [, and information obtained from MIB, Inc.][.] [Please note that any information received from MIB, Inc. is used in determining Evidence of Insurability for [Critical Illness] only. It will not be used in determining Evidence of Insurability for [Life or Disability].] Only information that is relevant to determining Evidence of Insurability for the coverage which you are currently requesting will be considered.

Form PA-9475 (CW)(HLA)-7

**Authorization**

I understand that Hartford Life And Accident Insurance Company may disclose the information in its files to its reinsurer(s), [MIB, Inc.] [(please note that any information received from MIB, Inc. is used in determining Evidence of Insurability for [Critical Illness] only, and will not be used in determining Evidence of Insurability for [Life or Disability])][.], other insurance companies, other persons and/or organizations performing business functions on behalf of Hartford Life And Accident Insurance Company, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me that relates to this application and that such requested information and the identity of the source of the information shall be released to me or, in the case of medical information, to a licensed medical person of my choice.

Further, I authorize Hartford Life And Accident Insurance Company to complete a Personal History Interview.

I agree that a photocopy of this authorization is valid as the original and understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This authorization shall be valid for [twenty-four (24)] months from the date signed below. This authorization may be revoked upon written request to Hartford Life And Accident Insurance Company, except to the extent that action has already been taken. However, I understand the revocation may be a basis for denying my insurance application and/or coverage and benefits.

Form PA-9475 (CW)(HLA)-8

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[[Fraud]

[Please read the statement that applies to your state of residence and sign this application.]

[For any Applicants that do not reside in the following states: Colorado, Florida, Kentucky, Maine, 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 may be guilty of a crime and may be subject to fines and confinement in 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 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 an insurance policy is subject to criminal and civil penalties.]

[For residents of New York] [(Applicable to Health Insurance Only)] [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 of 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.]

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[[Employee]: First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_ ]  
Form PA-9475 (CW)(HLA)-Header

[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 with the penalty of 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.]

Form PA-9475 (CW)(HLA)-9

**[PRE-EXISTING CONDITIONS LIMITATION – [Applicable to Disability Insurance Only] [- For Residents of NY]**

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

Form PA-9475 (CW)(HLA)-10

**Certification**

[I hereby represent that I have reviewed the above questions and that all statements and answers contained herein are full, complete, and true to the best of my knowledge and belief.] [For residents of Virginia only:] [I certify that I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.]

I hereby certify that I have received and read a copy of Hartford Life And Accident Insurance Company's Notice of Insurance Information Practices [ , including the MIB, Inc. Pre-notification].

This application will be made a part of the Policy.

Form PA-9475 (CW)(HLA)-11

[[Third Party Administrator] receives compensation for services to provide this program on behalf of the insurer; these services may include, but are not limited to, enrollments, serving, billing, marketing, brokerage, customer administration, claim services and communications.]

Form PA-9475 (CW)(HLA)-12

[ _____ ] [Employee] Signature (Required when submitting Evidence of Insurability)]	[ / / ] Date Signed]	[ _____ ] [Spouse] Signature (Required when submitting Evidence of Insurability)]	[ / / ] Date Signed]
---	-------------------------	---	-------------------------

[ _____ ] [Child] Signature (Parent/Legal Guardian of the Child is required to sign when submitting dependent Evidence of Insurability. Child is required to sign if they are: age 15 or older in NC; age 19 or older in AL, DE, NE; age 21 or older in MS; or 18 or older in all other states)]	[ / / ] Date Signed]
--	-------------------------

Form PA-9475 (CW)(HLA)-13

[The Hartford® is Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies in New York are underwritten by Hartford Life Insurance Company.]

[[Employee]: First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_ ]  
Form PA-9475 (CW)(HLA)-Header

[Please mail the completed [[Employer] Group Benefits Coverage Information] page and Evidence of Insurability application to:

The Hartford, Medical Underwriting

P.O. Box 2999

Hartford, CT 06104-2999

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](mailto:medical.uw@hartfordlife.com).]

Form PA-9475 (CW)(HLA)-14

[Questions? [Call 1-800-331-7234]]

Form PA-9475 (CW)(HLA)-15

[The Hartford® is Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies in New York are underwritten by Hartford Life Insurance Company.]

[[



]

[Applicant:  
Underwriting ID:  
Policyholder:  
Policy Number(s):]

**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
[200 Hopmeadow Street, Simsbury, Connecticut 06089]

Form PA-9475 (HLA) JOIMUS-Header

**JOINT / MUSCULOSKELETAL QUESTIONNAIRE**

[

1. Please indicate the disorder experienced/diagnosed:

- Arthritis (type: \_\_\_\_\_)
- Back/Neck pain
- Disc Disorder (torn, herniated, slipped, bulging, degenerative disc)
- Knee Disorder (dislocation, torn or ruptured meniscus, ligament or tendon, chondromalacia, Baker's cyst)
- Fibromyalgia
- Strain/sprain
- Fracture(s)
- Sciatica
- Joint disease
- Shoulder Disorder (rotator cuff injury, dislocation, torn, impingement)
- Bursitis
- Osteoporosis/Osteopenia
- Tendonitis
- Other (please specify): \_\_\_\_\_

2. Please indicate area(s) affected:

- Back  Neck  Shoulder  Elbow  Wrist  Finger(s)  Hip  Knee  Ankle
- Other (please specify): \_\_\_\_\_

3. Do you experience the following? Please check all that apply:

- Pain  Numbness  Burning  Stiffness
- Other (please specify): \_\_\_\_\_

4. Please provide date of initial diagnosis: \_\_\_\_\_ Number of episodes since you were diagnosed: \_\_\_\_\_ Please provide the most recent date that you experienced any of the above symptoms: \_\_\_\_\_.

5. When you experience any of the above symptoms, how do they impact your daily living including your work activities?

\_\_\_\_\_

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6. Please indicate treatment(s) received for this disorder:

Medication	Dosage	Date last taken	Date dose was changed

Chiropractic treatment    Physical Therapy    Injections    Surgery

Other (please specify): \_\_\_\_\_

Date(s) or frequency of treatment: \_\_\_\_\_

Date of last treatment: \_\_\_\_\_

Are any further treatments planned? Yes  No

If yes, please provide scheduled treatment: \_\_\_\_\_ Date (s) \_\_\_\_\_

7. Have you been released by a member of the medical profession to resume all activities without limitations or residuals?

Yes  No

If yes, please provide date recovered: \_\_\_\_\_

If no, are you currently on disability? Yes  No  If yes, please provide the effective date: \_\_\_\_\_

8. Have you lost time from work due to your disorder? Yes  No  If yes, please provide dates and the amount of time lost. \_\_\_\_\_

9. Please indicate your occupation and job duties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Are you being treated for any other condition? Yes  No  If yes, please provide diagnosis, treatment, and current status. \_\_\_\_\_  
\_\_\_\_\_

11. Please provide the full name and complete address of the physician who has the most complete and up-to-date medical information regarding all medical conditions. (Please attach an additional sheet if necessary)

Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_  
State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_]

Form PA-9475 (HLA) JOIMUS-1

**Fraud**

**Please read the statement that applies to your state of residence and sign this application.**

**For any Applicants that do not reside in the following states: California, Colorado, Florida, Kentucky, Maine, 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 may be 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,

finer, 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 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 an insurance policy is subject to criminal and civil penalties.

**For residents of New York (Applicable to Disability Insurance Only):** 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 of 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 with the penalty of 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.

### **Certification**

I hereby represent that I have reviewed the above questions and that all statements and answers contained herein are full, complete, and true to the best of my knowledge and belief. For residents of Virginia only: I certify that I have read, or had read to me, the completed application and that I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

This application will be made a part of the Policy.

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

[[



]

[Applicant:  
Underwriting ID:  
Policyholder:  
Policy Number(s):]

**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
[200 Hopmeadow Street, Simsbury, Connecticut 06089]]

Form PA-9475 (HLA) PSY-Header

**PSYCHOLOGICAL QUESTIONNAIRE**

[

1. Please indicate the diagnosis provided by your physician:

- Depression
- Postpartum Depression
- Obsessive Compulsive Disorder (OCD)
- Chemical Imbalance
- Attention Deficit Hyperactivity Disorder (ADHD) / Attention Deficit Disorder (ADD)
- Anxiety
- Panic Attacks
- Dysthymia
- Other (please specify): \_\_\_\_\_
- Post-Traumatic Stress Disorder
- Bipolar Disorder

2. Please provide the date of onset \_\_\_\_\_ and date of diagnosis \_\_\_\_\_.

3. Do you experience the following? Please check all that apply:

- Fatigue
- Insomnia
- Tearfulness
- Other (please specify): \_\_\_\_\_
- Sadness
- Nervousness
- Hopelessness
- Suicidal Thoughts
- Inability to Concentrate
- Change in Sleeping Habits
- Loss of Appetite
- Heart Racing

4. Please provide the most recent date that you experienced any of the above symptoms: \_\_\_\_\_

5. Was this a one-time occurrence? Yes  No  If no, please provide the number of occurrences experienced since initial onset of the above symptom(s): \_\_\_\_\_

6. Please provide details for all treatment(s) received for this disorder:

a.

Medication	Dosage	Date last taken	Date dose was changed

- b. Psychotherapy: Date(s) or frequency \_\_\_\_\_
- c. Hospitalization: Date(s) \_\_\_\_\_
- d. Day Treatment Program: Date(s) or frequency \_\_\_\_\_
- e. Other (please specify): \_\_\_\_\_

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7. Have you lost time from work due to this disorder? Yes  No  If yes, please provide dates and the amount of time lost. \_\_\_\_\_  
\_\_\_\_\_
8. At the time when you were experiencing symptoms, how did this disorder impact your daily living including your social activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. a. Have you ever sought medical treatment from a member of the medical profession because of drug usage? Yes  No  If yes, please provide date(s) of treatment. \_\_\_\_\_
- b. Have you ever sought medical treatment from a member of the medical profession because of alcohol usage? Yes  No  If yes, please provide date(s) of treatment. \_\_\_\_\_
10. Are you being treated for any other condition? Yes  No  If yes, please provide diagnosis, treatment, and current status. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Please provide the full name and complete address of the physician who has the most complete and up-to-date medical information regarding all medical conditions. (Please attach an additional sheet if necessary)

Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State/Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_]

Form PA-9475 (HLA) PSY-1

**Fraud**

Please read the statement that applies to your state of residence and sign this application.

**For any Applicants that do not reside in the following states: California, Colorado, Florida, Kentucky, Maine, 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 may be guilty of a crime and may be subject to fines and confinement in prison.

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**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.

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**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 an insurance policy is subject to criminal and civil penalties.

**For residents of New York (Applicable to Disability Insurance Only):** 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 of 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 with the penalty of 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.

### Certification

I hereby represent that I have reviewed the above questions and that all statements and answers contained herein are full, complete, and true to the best of my knowledge and belief. For residents of Virginia only: I certify that I have read, or had read to me, the completed application and that I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

This application will be made a part of the Policy.

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

[



]

[Applicant:  
Underwriting ID:  
Policyholder:  
Policy Number(s):]

**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
[200 Hopmeadow Street, Simsbury, Connecticut 06089]]

Form PA-9475 (HLA) RESP-Header

**RESPIRATORY QUESTIONNAIRE**

[

1. Please indicate the disorder experienced/diagnosed:

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Allergies                     | <input type="checkbox"/> Upper respiratory infection                  |
| <input type="checkbox"/> Pneumonia   | <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Pleurisy                                     |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Chronic cough                 | <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Other (please specify): _____ |   |

2. Please provide the date of the initial diagnosis. \_\_\_\_\_

3. Do you experience the following? Please check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Shortness of breath when resting | <input type="checkbox"/> Frequent wheezing  |
| <input type="checkbox"/> Shortness of breath when talking | <input type="checkbox"/> Daytime Sleepiness |
| <input type="checkbox"/> Other (please specify): _____    |   |

4. Please provide the most recent ~~last~~ date that you experienced any of the above symptoms: \_\_\_\_\_

5. Was this a one-time occurrence? Yes  No  If no, please provide the following:

- The frequency per year. \_\_\_\_\_
- The date of the last occurrence. \_\_\_\_\_

6. Please provide details for all treatment received for this disorder:

Medication	Dosage	Frequency	Date last taken

Has your medication, schedule or treatments routine been changed within the last 12 months? Yes  No  If yes, please provide the date \_\_\_\_\_ and the reason for change \_\_\_\_\_.

- Emergency room: Date(s) or frequency \_\_\_\_\_
- Hospitalization: Date(s) \_\_\_\_\_
- Supplemental oxygen use: Yes  No  As Needed
- Sleep Apnea treatment: Continuous Positive Airway Pressure (CPAP)   
BiLevel Positive Airway Pressure (BiPAP)  Surgery

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f. Other (please specify): \_\_\_\_\_

7. Diagnostic Testing Performed:

	Date Performed:	Results:
<input type="checkbox"/> Chest x-ray	_____	_____
<input type="checkbox"/> Pulmonary Function	_____	_____
<input type="checkbox"/> Sleep Study*	_____	_____

\*Apnea Index (AI) prior to treatment \_\_\_\_\_ after treatment \_\_\_\_\_  
(This information can be obtained from the physician who treated you for sleep apnea.)

8. Have you lost time from work due to this disorder? Yes  No  If yes, please provide dates and the amount of time lost. \_\_\_\_\_  
\_\_\_\_\_

9. Do you currently smoke? Yes  No  If yes, how many packs per day? \_\_\_\_\_

10. If you do not currently smoke, have you smoked in the past? Yes  No   
If Yes, please provide date you quit. \_\_\_\_\_

11. Are you being treated for any other condition? Yes  No  If yes, please provide diagnosis, treatment, and current status. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Please provide the full name and complete address of the physician who has the most complete and up-to-date medical information regarding all medical conditions. (Please attach an additional sheet if necessary)

Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_  
State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Form PA-9475 (HLA) RESP-1

**Fraud**

Please read the statement that applies to your state of residence and sign this application.

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**For residents of New York (Applicable to Disability Insurance Only):** 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.

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**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 with the penalty of 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.

**Certification**

I hereby represent that I have reviewed the above questions and that all statements and answers contained herein are full, complete, and true to the best of my knowledge and belief. For residents of Virginia only: I certify that I have read, or had read to me, the completed application and that I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

This application will be made a part of the Policy.

Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

[Applicant's Full Name: (Please print – First Name, Middle Initial, Last Name) \_\_\_\_\_]

[[



[Applicant:  
Underwriting ID:  
Policyholder:  
Policy Number(s):]

**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

[200 Hopmeadow Street, Simsbury, Connecticut 06089]

[EXTENDED EVIDENCE OF INSURABILITY ]]

The Hartford® is Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies in New York are underwritten by Hartford Life Insurance Company.

Employee Name: _____ Employee [SSN]: _____	Mailing Address: Hartford Life and Accident Insurance Company [Group Medical Underwriting P.O. Box 2999 Hartford, CT 06104]
Policyholder Name: _____ Policy Number: _____ (Company Name)	

1. Applicant's Full Name: (Please print – First Name, Middle Initial, Last Name)  
\_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  M or  F  
(check one)

Form PA-9475 EEOI (CW)(HLA)-1 Administration

[Medical Questionnaire

[(Continued)]

2. To the best of your knowledge and belief, within the past 5 years have you:		YES	NO
A	Been convicted of drug possession driving under the influence (DUI)/operating under the influence (OUI)/driving while intoxicated (DWI) or any other charge related to the influence of alcohol, been treated by a licensed medical provider for drug addiction or alcoholism, regularly taken controlled drugs other than as prescribed by your physician or used barbiturates or amphetamines?	<input type="checkbox"/>	<input type="checkbox"/>
B	Had an application for life, health, or accident insurance rejected, rated up, restricted, postponed or withdrawn? (California or Missouri residents – do not answer this question)	<input type="checkbox"/>	<input type="checkbox"/>
C	Applied for or received any disability insurance?	<input type="checkbox"/>	<input type="checkbox"/>
D	Been classified as 4F or been discharged from the service because of a disability?	<input type="checkbox"/>	<input type="checkbox"/>
E	Had or been advised by a licensed medical provider to have, any surgical operations, x-rays, heart examinations, electrocardiogram, blood or other laboratory studies (for residents of California, Maine, Minnesota, New York and Vermont: excluding Human Immunodeficiency Virus (HIV) tests?	<input type="checkbox"/>	<input type="checkbox"/>
F	Used insulin or been on a restricted diet, or had sugar or albumin in the urine?	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate details for above questions (including # of episodes, duration, severity, date of last symptom, current status, treatment, medications and dosages, test results, any further treatments planned and the name of the physician or hospital that treated you). For Florida residents: Do not provide details concerning Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)

Item #:	Date:	Details:

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3. To the best of your knowledge and belief, within the past 5 years have you been treated by a licensed medical provider for:		YES	NO
A	Nervous breakdown, anxiety, depression, dizziness, loss of consciousness, epilepsy, convulsions, frequent or severe headaches, or other mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
B	Ear discharge or impairment of hearing, speech, or sight?	<input type="checkbox"/>	<input type="checkbox"/>
C	Asthma, pleurisy, spitting of blood, tuberculosis, emphysema, chronic cough, or other respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
D	Arthritis, rheumatic fever, gout, deformity, or any disorder of the muscles, bones, or joints?	<input type="checkbox"/>	<input type="checkbox"/>
E	Heart trouble, heart murmur, palpitations, pain in the chest, angina pectoris, high blood pressure, cholesterol, anemia, varicose veins, or other disorder of the blood (for residents of New York, Maine or Vermont: excluding Human Immunodeficiency Virus (HIV) tests) or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
F	Indigestion, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, Gastroesophageal Reflux Disease GERD, jaundice, hepatitis or any disorder of the liver or gastrointestinal tract?	<input type="checkbox"/>	<input type="checkbox"/>
G	Kidney disease, renal colic, kidney stones, syphilis, any disorder of the bladder, prostate or other genitourinary organs?	<input type="checkbox"/>	<input type="checkbox"/>
H	Diabetes, thyroid or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
I	Cancer, cyst or any other tumor or skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>
J	Been diagnosed as having, or been treated, by a licensed medical provider (for residents of Vermont: by a licensed medical physician) for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
K	Any disorder of the breast, uterus, ovaries, cervix or fallopian tubes?	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate details for above questions (including # of episodes, duration, severity, date of diagnosis, date of last symptom, current status, treatment, medications and dosages, test results, any further treatments planned and the name of the physician or hospital that treated you). For residents of Florida: Do not provide details concerning Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)

Item#:	Date:	Details:

4. To the best of your knowledge and belief, within the last 5 years have you:		YES	NO
A	Been diagnosed with or treated by a licensed medical provider for any disease, injury or had an operation not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
B	Consulted a physician, psychiatrist or other practitioner for a general exam or any other reason not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
C	Been a patient in any hospital or sanitarium for any reason not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>

5. CURRENTLY:		YES	NO
A	Do you drink alcohol? If YES, please indicate how often _____ How Much? _____	<input type="checkbox"/>	<input type="checkbox"/>
B	Do you experience any known symptoms, disorder or have a condition that may impair your health or require an operation? For residents of Florida and Minnesota: Do not answer this question.	<input type="checkbox"/>	<input type="checkbox"/>
C	Do you take any medication for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
D	Are you pregnant? (If YES, give expected delivery date and pre-pregnancy weight)	<input type="checkbox"/>	<input type="checkbox"/>
E	Do you currently use tobacco products (including cigarettes, cigars, dip, snuff, chewing tobacco and nicotine patches or gum)? <input type="checkbox"/> Yes <input type="checkbox"/> No Which statement best describes your use of tobacco products. <input type="checkbox"/> Not within the last 4 years <input type="checkbox"/> Not within last 12 months <input type="checkbox"/> Never		

6. Please indicate details for above questions (including # of episodes, duration, severity, date of diagnosis, date of last symptom, current status, treatment, medications and dosages, test results, any further treatments planned and the name of the physician or hospital that treated you). For residents of Florida: Do not provide details concerning Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)

Item #:	Date:	Details:
7. Please provide the complete name and address of your primary care physician:		
Name: _____		
Address: _____		
Telephone: _____ ]		

[[2.][8.] Please indicate applicant's build below:			
Height	_____ft. _____in. (without shoes)	Weight	_____lbs. (without shoes)
	Did you measure?:    YES <input type="checkbox"/> NO <input type="checkbox"/>		Did you weigh?:        YES <input type="checkbox"/> NO <input type="checkbox"/>
Blood Pressure / Pulse at rest: (Take three, 10 minutes apart and record all three)			
Systolic:	(1.)	(2.)	(3.)
Diastolic:	(1.)	(2.)	(3.)
Pulse at rest _____			
[3.] [9.] Examiner Questions:			
a. Are you forwarding a specimen to the lab? <input type="checkbox"/> Yes <input type="checkbox"/> No			
b. Which of the following did you use to identify the Applicant? <input type="checkbox"/> Drivers license with picture <input type="checkbox"/> Other picture ID			
Please indicate below what the other picture ID is: _____ ]			

**[Fraud**

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[Applicant's Full Name: (Please print – First Name, Middle Initial, Last Name)\_\_\_\_\_]

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**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 with the penalty of 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.

**Certification**

I hereby represent that all statements and answers as written or printed herein are full, complete and true to the best of my knowledge and belief. I agree that they are to be considered the basis of any insurance issued hereon and no agent has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the company's rights or requirements, or to make or alter any contract. For residents of Virginia: I certify that I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

This application will be made a part of the Policy.]

Print Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

[Signature of Applicant: \_\_\_\_\_

Dated: \_\_\_\_\_]

Form PA-9475 EEOI (CW)(HLA)-5 Applicant Signature

[Witnessed by Examiner: \_\_\_\_\_

Dated: \_\_\_\_\_]

Form PA-9475 EEOI (CW)(HLA)-6 Examiner Signature

SERFF Tracking Number: HARL-127648171 State: Arkansas  
 Filing Company: Hartford Life and Accident Insurance Company State Tracking Number: 50194  
 Company Tracking Number: GBD\_CI\_GCF\_PHA FILING\_2011\_11  
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness  
 Limited Benefit  
 Product Name: GCF\_AR\_HLA\_CI\_PA-9475 (CW)(HLA)\_2011\_PHA Filing  
 Project Name/Number: /2971

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	11/07/2011
<b>Comments:</b>		
<b>Attachment:</b> 10.27.11_Readability Certification_EOI_HLA.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	11/07/2011
<b>Bypass Reason:</b> N/A as this is not a policy filing.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification-JOIMUS	Approved-Closed	11/07/2011
<b>Comments:</b>		
<b>Attachment:</b> 10.27.11_Readability Certification_JOIMUS_HLA.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification-PSY	Approved-Closed	11/07/2011
<b>Comments:</b>		
<b>Attachment:</b> 10.27.11_Readability Certification_PSY_HLA.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification-RESP	Approved-Closed	11/07/2011
<b>Comments:</b>		

SERFF Tracking Number: HARL-127648171 State: Arkansas  
Filing Company: Hartford Life and Accident Insurance Company State Tracking Number: 50194  
Company Tracking Number: GBD\_CI\_GCF\_PHA FILING\_2011\_11  
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness  
Limited Benefit  
Product Name: GCF\_AR\_HLA\_CI\_PA-9475 (CW)(HLA)\_2011\_PHA Filing  
Project Name/Number: /2971

**Attachment:**

10.27.11\_Readability Certification\_RESP\_HLA.pdf

**Satisfied - Item:** Flesch Certification-EEOI

**Comments:**

**Attachment:**

10.27.11\_Readability Certification\_EEOI\_HLA.pdf

**Item Status:**

Approved-Closed

**Status**

**Date:**

11/07/2011

**Satisfied - Item:** Forms List

**Comments:**

**Attachment:**

10.27.11\_Forms List\_CI.pdf

**Item Status:**

Approved-Closed

**Status**

**Date:**

11/07/2011

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY  
Certification of Readability for  
Application Form PA-9475 (CW)(HLA)

I hereby certify that the above named forms comply with the N.A.I.C. Model Policy Language Simplification Act. The forms have been tested by an acceptable method specified in the model law and an average Flesch score of 51.2 was obtained for the application form.

Unless we hear from you to the contrary, we will assume that this certification satisfies the certification requirements for compliance with any present or future readability law enacted by your state. We understand that this certification will not be valid to the extent that there is a material difference between the readability law of your state and the N.A.I.C. model.



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Dana MacKinnon, Vice President  
Officer/Title

October 5, 2011

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Date

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY  
Certification of Readability for  
Questionnaire Form PA-9475 (HLA) JOIMUS

I hereby certify that the above named forms comply with the N.A.I.C. Model Policy Language Simplification Act. The forms have been tested by an acceptable method specified in the model law and an average Flesch score of 51.4 was obtained for the questionnaire form.

Unless we hear from you to the contrary, we will assume that this certification satisfies the certification requirements for compliance with any present or future readability law enacted by your state. We understand that this certification will not be valid to the extent that there is a material difference between the readability law of your state and the N.A.I.C. model.



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Dana MacKinnon, Vice President  
Officer/Title

October 5, 2011

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Date

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY  
Certification of Readability for  
Questionnaire Form PA-9475 (HLA) PSY

I hereby certify that the above named forms comply with the N.A.I.C. Model Policy Language Simplification Act. The forms have been tested by an acceptable method specified in the model law and an average Flesch score of 57.3 was obtained for the questionnaire form.

Unless we hear from you to the contrary, we will assume that this certification satisfies the certification requirements for compliance with any present or future readability law enacted by your state. We understand that this certification will not be valid to the extent that there is a material difference between the readability law of your state and the N.A.I.C. model.



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Dana MacKinnon, Vice President  
Officer/Title

October 5, 2011

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Date

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY  
Certification of Readability for  
Questionnaire Form PA-9475 (HLA) RESP

I hereby certify that the above named forms comply with the N.A.I.C. Model Policy Language Simplification Act. The forms have been tested by an acceptable method specified in the model law and an average Flesch score of 59.6 was obtained for the questionnaire form.

Unless we hear from you to the contrary, we will assume that this certification satisfies the certification requirements for compliance with any present or future readability law enacted by your state. We understand that this certification will not be valid to the extent that there is a material difference between the readability law of your state and the N.A.I.C. model.



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Dana MacKinnon, Vice President  
Officer/Title

October 5, 2011

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Date

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY  
Certification of Readability for  
Application Form PA-9475 EEOI (CW)(HLA)

I hereby certify that the above named forms comply with the N.A.I.C. Model Policy Language Simplification Act. The forms have been tested by an acceptable method specified in the model law and an average Flesch score of 50.2 was obtained for the application form.

Unless we hear from you to the contrary, we will assume that this certification satisfies the certification requirements for compliance with any present or future readability law enacted by your state. We understand that this certification will not be valid to the extent that there is a material difference between the readability law of your state and the N.A.I.C. model.



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Dana MacKinnon, Vice President  
Officer/Title

October 5, 2011

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Date

<b>GROUP CRITICAL ILLNESS FORMS LIST</b>	
<b>Form #</b>	<b>Description</b>
PA-9475 (CW)(HLA)	Evidence of Insurability
PA-9475 EEOI (CW)(HLA)	Extended Evidence of Insurability
PA-9475 (HLA) JOIMUS	Joint/Musculoskeletal Questionnaire
PA-9475 (HLA) PSY	Psychological Questionnaire
PA-9475 (HLA) RESP	Respiratory Questionnaire