



**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
 200 Hopmeadow Street, Simsbury, Connecticut 06089  
**EXAMINATION FOR GROUP INSURANCE**

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.

**DECLARATION MADE TO EXAMINER**

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

1. Applicant's Full Name: (Please print - First Name, Middle Initial, Last Name) \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: M or F  
(circle one)

**Medical Questionnaire: All questions should be asked by the examiner (or licensed nurse assistant) to promote understanding, completeness, and accuracy of answers. The completed form should be signed and witnessed by the examiner.**

2. Have you EVER:	YES	NO
a. Been convicted of or pled guilty to drug possession or DUI/OUI/DWI or any other charge related to the influence of alcohol, been treated for drug addiction or alcoholism, regularly taken controlled drugs which were not prescribed by a physician or used barbiturates or amphetamines?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had your application for life, health, or accident insurance rejected, rated up, restricted, postponed or withdrawn?	<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 to have any surgical operations, x-rays, heart examinations, electrocardiogram, blood or other laboratory studies?	<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, results, and the name of the physician or hospital that treated you).**

<u>Item #:</u>	<u>Date:</u>	<u>Details:</u>

3. Have you EVER had or been treated 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 or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
f. Indigestion, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, 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 genitor-urinary 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 member of the medical profession, 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"/>
<b>Please indicate details for above questions. (Including # of episodes, duration, severity, date of last symptom, current status, treatment, results, and the name of the physician or hospital that treated you).</b>		
<u>Item#:</u>	<u>Date:</u>	<u>Details:</u>
<b>4. Have you WITHIN the LAST 5 Years:</b>		
a. Had or been treated for any disease, injury or had an operation not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
<b>5. CURRENTLY:</b>		
a. Do you drink alcohol? If YES, please indicate how often _____ How Much? _____	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you experience any symptoms, disorder or have a condition that may impair your health or require an operation?	<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		
f. Current occupation: _____		
During the last 3 years, have you engaged in a hazardous occupation (such as: underground mining, high-rise construction, offshore drilling, iron work, tunnel/subway construction, explosive handling, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide details for the past three years:		
Date: _____ Project/Duties: _____		
Date: _____ Project/Duties: _____		
Annual Salary \$ _____		
g. Avocation Question:		
<b>Do you participate in any hazardous activities?</b> (Such as: aircraft flying other than as a passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, organized motorcycle racing, or any type of motorized racing)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide details:		

Please indicate details for above questions. (Including # of episodes, duration, severity, date of last symptom, current status, treatment, results, and the name of the physician or hospital that treated you).					
Item #:	Date:	Details:			
<b>6. Please indicate applicant's build and family history below:</b>					Please provide the complete name and address of your primary care physician: Name: _____  Address: _____  Telephone: _____
Height	_____ ft. _____ in.  (HGT & WGT without shoes)				
Weight	_____ lbs.  Pulse at REST _____				
Did you measure:    YES <input type="checkbox"/> NO <input type="checkbox"/>					<b>7. Blood Pressure</b> (Take three, 10 minutes apart and record all three)  _____  Systolic:                    (1).                    (2).                    (3).  Diastolic:                    (1).                    (2).                    (3).
Did you weigh:            YES <input type="checkbox"/> NO <input type="checkbox"/>					
Has applicant gained or lost within the last year? +/- _____ lbs.					
Reason for loss or gain: _____					
Family History	AGE	Living State of Health	AGE	<b>8. Examiner Questions:</b>	
Father				a. Have you reason to believe or suspect that the proposed Insured is under the influence of alcohol or narcotics? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Are you forwarding a specimen to the lab? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Which of the following did you use to identify the proposed? <input type="checkbox"/> Drivers license with picture <input type="checkbox"/> Other picture ID <b>Please indicate below what the other picture ID is:</b> _____	
Mother					
Brothers Number (    )					
Sisters Number (    )					

I hereby declare 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.

I hereby expressly waive, to such extent as may be lawful, on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder, all provisions of law forbidding any physician or other person who has previously attended or examined me from disclosing any knowledge or information thereby acquired, and I expressly authorize such physician or other person to make such disclosures.

**The following fraud statement is 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.

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

Signature of Proposed Insured: \_\_\_\_\_ Dated: \_\_\_\_\_

Witnessed by Examiner: \_\_\_\_\_ Dated: \_\_\_\_\_

**HARTFORD LIFE INSURANCE COMPANIES**  
**Individual Life Operations**  
**P.O. Box 64271**  
**St. Paul, Minnesota 55164-0271**  
**Telephone Number: (800) 246-4819**



### **HIV ANTIBODY TESTING CONSENT FORM**

The insurance company to which you have applied may request a blood, urine, or oral fluid sample from you for testing. One test will be to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV). HIV is the virus which causes AIDS. The New Hampshire Unfair Insurance Trade Practices Act (RSA 417) provides for an insurance company to test for the presence of an antibody or antigen to HIV only upon your written consent. The results of this test may determine your eligibility to acquire insurance. By signing this form you have consented to the HIV test and the reporting of the test results to the insurance company taking your application. Positive test results will not be disclosed except as authorized by you in writing. Negative and indeterminate (inconclusive) test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. The insurance company and any other party receiving the negative or indeterminate test results will maintain the results of your HIV antibody test as confidential.

If your test results indicate the presence of antibodies to HIV, or if your test results cannot be accurately determined, the insurance company will report a "nonspecific abnormality" to the Medical Information Bureau. The Medical Information Bureau contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having an abnormal HIV antibody test because many abnormalities are reported to the Bureau under the same classification.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred within the previous 3-6 months.

If your HIV antibody test is positive, it does not mean that you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needles, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Nor does absence of HIV antibodies mean that you are immune to the virus.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions, you should consult your own physician or call the New Hampshire AIDS Hotline at 1-800-852-AIDS.

WHITE - HOME OFFICE

CANARY - PROPOSED INSURED

PINK - AGENT/EXAMINER

**HARTFORD LIFE INSURANCE COMPANIES**  
Individual Life Operations  
P.O. Box 64271  
St. Paul, Minnesota 55164-0271  
Telephone Number: (800) 246-4819



**HIV ANTIBODY TESTING CONSENT FORM (Cont'd.)**

The insurance company will notify you if your test results are positive or if your results cannot be accurately determined. If you request, the company will also send your results to a physician or other person. You should request that your results be sent to your private physician so that he/she can interpret them for you.

In the event of a positive or indeterminate test result, I authorize disclosure to the following physician or other person or entity:

\_\_\_\_\_  
Name of Physician or other person/entity

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

**Informed Consent**

I have read and understand this information. I voluntarily consent to provide a sample of my blood, urine, or oral fluid, the testing of that blood, urine, or oral fluid and the disclosure of the test results as described above.

_____ Name of Proposed Insured	_____ Signature of Proposed Insured
_____ Date of Birth	_____ State of Residence
_____ Date Signed by Proposed Insured	_____ Signature of Witness