THE HARTFORD

HARTFORD LIFE 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: _____

Policyholder Name: _____ Policy Number: _____
(Company Name)

Mailing Address:
Hartford Life Insurance Company
Group Medical Underwriting
P.O. Box 2999
Hartford, CT 06104

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 addition or alcoholism, regularly taken controlled drugs which were not prescribed by a physician or used barbiturates or amphetamines?	☐	☐
b. Had your application for life, health, or accident insurance rejected, rated up, restricted, postponed or withdrawn?	☐	☐
c. Applied for or received any disability insurance?	☐	☐
d. Been classified as 4F or been discharged from the service because of a disability?	☐	☐
e. Had or been advised to have any surgical operations, x-rays, heart examinations, electrocardiogram, blood or other laboratory studies?	☐	☐
f. Used insulin or been on a restricted diet, or had sugar or albumin in the urine?	☐	☐

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:

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?	☐	☐
b. Ear discharge or impairment of hearing, speech, or sight?	☐	☐
c. Asthma, pleurisy, spitting of blood, tuberculosis, emphysema, chronic cough, or other respiratory disorder?	☐	☐
d. Arthritis, rheumatic fever, gout, deformity, or any disorder of the muscles, bones, or joints?	☐	☐
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?	☐	☐
f. Indigestion, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, GERD, jaundice, hepatitis or any disorder of the liver or gastrointestinal tract?	☐	☐

g. Kidney disease, renal colic, kidney stones, syphilis, any disorder of the bladder, prostate or other genitor-urinary organs?	☐	☐
h. Diabetes, thyroid or other endocrine disorders?	☐	☐
i. Cancer, cyst or any other tumor or skin disorder?	☐	☐
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)?	☐	☐
k. Any disorder of the breast, uterus, ovaries, cervix or fallopian tubes?	☐	☐

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:

4. **Have you WITHIN the LAST 5 Years:**	**YES**	**NO**
a. Had or been treated for any disease, injury or had an operation not already mentioned?	☐	☐
Consulted a physician, psychiatrist or other practitioner for a general exam or any other reason not already mentioned?	☐	☐
c. Been a patient in any hospital or sanitarium for any reason not already mentioned?	☐	☐
5. **CURRENTLY:**	☐	☐
a. Do you drink alcohol? If YES, please indicate how often _____ How Much? _____	☐	☐
b. Do you experience any symptoms, disorder or have a condition that may impair your health or require an operation?	☐	☐
c. Do you take any medication for any reason?	☐	☐
d. Are you pregnant? (If YES, give expected delivery date and pre-pregnancy weight)	☐	☐

e. Do you currently use tobacco products (including cigarettes, cigars, dip, snuff, chewing tobacco and nicotine patches or gum)?
☐ Yes ☐ No
Which statement best describes your use of tobacco products.
☐ Not within the last 4 years ☐ Not within last 12 months ☐ 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.)? ☐ Yes ☐ No
If yes, please provide details for the past three years:

Date: _____ Project/Duties: _____

Date: _____ Project/Duties: _____

Annual Salary $ _____

g. Avocation Question:
Do you participate in any hazardous activities? (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)? ☐ Yes ☐ 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:

6. Please indicate applicant's build and family history below:

Height	_____ft. _____in. (HGT & WGT without shoes)
Weight	_____lbs. Pulse at REST _____

Please provide the complete name and address of your primary care physician:
Name: _____
Address: _____
Telephone: _____

Did you measure: YES ☐ NO ☐

Did you weigh: YES ☐ NO ☐

Has applicant gained or lost within the last year? +/- _____**lbs.**
Reason for loss or gain:
_____

7. Blood Pressure
(Take three, 10 minutes apart and record all three)

Systolic: (1). (2). (3).

Diastolic: (1). (2). (3).

Family History	AGE	Living State of Health	AGE	Not Living Cause of Death
Father				
Mother				
Brothers Number ( )				
Sisters Number ( )				

8. Examiner Questions:

a. Have you reason to believe or suspect that the proposed insured is under the influence of alcohol or narcotics?
☐ Yes ☐ No

b. Are you forwarding a specimen to the lab?
☐ Yes ☐ No

c. Which of the following did you use to identify the proposed?
☐ Drivers license with picture ☐ Other picture ID
Please indicate below what the other picture ID is:
_____

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
National Service Center
P.O. Box 59179
Minneapolis, MN 55459-0179
Telephone Number: (800) 541-6757

Hartford Life

NOTICE AND CONSENT FOR BLOOD OR OTHER BODILY FLUID SAMPLES TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the company with whom you are applying for insurance has requested that you provide a sample of your blood or other bodily fluid sample for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All tests results will be treated confidentially. They will be reported by the laboratory to the company with whom you are applying for insurance. When necessary for business reasons in connection with insurance you have or have applied for with the company with whom you are applying for insurance, the company with whom you are applying for insurance may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. These aforementioned affiliates, reinsurers, employees or contractors may have access to your insurance file. If the company with whom you are applying for insurance is a member of the Medical Information Bureau (MIB, Inc.) and if the test results for HIV antibodies/antigens are other than normal, the company with whom you are applying for insurance will report to the MIB, Inc. a generic code which signifies only a non-specific blood or other bodily fluid samples test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you. You have the right to request the names of the specific individuals or organizations that have access to such information as described above.

The company with whom you are applying for insurance may also contact you if the test results are positive or indeterminate. The company with whom you are applying for insurance may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood or other bodily fluid sample abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

WHITE - HOME OFFICE CANARY - PROPOSED INSURED PINK - AGENT/EXAMINER

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NOTICE AND CONSENT FOR BLOOD TESTING
WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING (Cont'd)

If I test positive or indeterminate for the antibodies to the AIDS virus (HIV), please send the results to:

☐ Me, at the following address: _____

☐ My physician or other person: _____
Name

_____
Address City, State, Zip Code

If I do not designate a person or physician to receive positive or indeterminate test results as requested above, personal face to face counseling is available through the Virginia Department of Health. For information, I can contact my local Health Department or the Virginia Health Department at 1-800-533-4148.

☐ I wish to have a copy of my negative/normal test results sent to me at the following address:

_____

I have read and I understand this Notice of Consent For Blood or Other Bodily Fluid Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood or other bodily fluid samples from me, the testing of that blood or other bodily fluid sample, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ ____/____/____
Proposed Insured (Please Print) Date of Birth

_____ ____/____/____ _____
Signature of Proposed Insured Date State of Residence

_____ _____
Examiner's Name Examiner's Address

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☐ Me, at the following address: _____

☐ My physician or other person: _____
Name

_____
Address City, State, Zip Code

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I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ ____/____/____
Proposed Insured (Please Print) Date of Birth

_____ ____/____/____ _____
Signature of Proposed Insured Date State of Residence

_____ _____
Examiner's Name Examiner's Address

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