



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: _____	Mailing Address: Hartford Life 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b. Had your application for life, health, or accident insurance rejected, rated up, restricted, postponed or withdrawn?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"/>

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>

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?	<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"/>

5. CURRENTLY:

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)?
 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).

<u>Item #:</u>	<u>Date:</u>	<u>Details:</u>
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6. Please indicate applicant's build and family history below:		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"/>	7. Blood Pressure (Take three, 10 minutes apart and record all three)
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: _____	

	Systolic:	(1).	(2).	(3).	8. Examiner Questions: 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 Please indicate below what the other picture ID is: _____
	Diastolic:	(1).	(2).	(3).	

Family History	AGE	Living State of Health	AGE	Not Living Cause of Death
Father				
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 59179
Minneapolis, MN 55459-0179
Telephone Number: (800) 541-6757



HIV TESTING INFORMATION STATEMENT & CONSENT FORM

Vermont law requires that this entire statement be read aloud to you. It contains important information about HIV testing and your rights under Vermont law. A copy of it will be given to you to keep.

The insurance company you are applying to for coverage may want to take a sample from you to be tested by a laboratory for the presence of antibodies to the HIV virus. This information may be used as part of its decision whether to sell you insurance coverage. The insurance company may request a sample of your blood, urine or oral fluids (OMT) in order to conduct the test. The insurance company will pay for this test.

HIV is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). Presence of antibodies in the sample means that a person has been infected with the HIV virus. While a positive HIV antibody test result does not mean that you have AIDS, it does mean that you are at a seriously increased risk of developing AIDS. A negative test result means that no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not guarantee that you have not been infected with the virus. In addition, the absence of HIV antibodies does not mean that you are immune to the virus.

If after listening to this statement you do not wish to be tested, do not sign the informed consent form and the application process will end. You may consult, at your expense, with a personal physician or counselor or the state health department before deciding whether to consent to this testing. In addition, you may obtain an anonymous test before deciding to consent to this testing (call the Vermont Aids Hotline for information about free testing, the number is listed below) and any delay will not affect the status of your application or policy.

You may choose to receive the test results directly or to designate in writing on the informed consent form any other person whom you want to receive the results.

All test results will be treated confidentially. The laboratory that conducts the test will report the results to the insurance company, which may in turn report results to its affiliates, reinsurers, medical personnel and insurance support organizations that are involved in the decision by the insurer to sell you insurance. Test results will not be shared with your insurance agent or broker. You have the right to sue a person for damages arising from the unauthorized negligent or knowing disclosure of HIV related test results.

If your test result is positive or indeterminate, the insurance company may report a nonspecific test code to the medical information bureau (MIB). The MIB is a central computerized facility that keeps on file the health information of the applicants for life and health insurance for use by insurance companies. In addition, positive test results must be reported to the Vermont Department of Health using a unique identifier code.

You have rights that include the following:

1. If a test is indeterminate, you may request in writing to be re-tested after six months, but not later than eight months. Pre-existing insurance will not be affected. If the new test is indeterminate or negative, a new application for coverage may not be denied based on either test, and any prior decision to grant a substandard classification or exclusion based on prior HIV-related test results will be reversed;
2. If the test result of urine or oral fluids is positive or indeterminate, the insurance company must provide you with the opportunity to retest once, within 30 days following receipt of those test results. You have the option of choosing a blood, urine or oral sample for that retest.
3. If you are denied insurance because of a positive test result, you may request a retest once within the three-year period following the date of the most recent test or if an alternative test has been approved for use by the Vermont Insurance Commissioner. If such retest is negative, an insurer may not deny coverage based upon the initial test results.

It is very important to seek counseling in the event you test positive for HIV antibodies. You can obtain helpful information from the Vermont AIDS Hotline at (800) 882-2437 and the Centers for Disease Control and Prevention at (800) 342-2437.

You will now be asked to sign a written informed consent form permitting the insurance company to have you tested for HIV antibodies.

Informed Consent *To be signed at the time when medical professional or company agent obtains sample.*

This statement has been read aloud to me and I understand this **HIV TESTING INFORMATION STATEMENT & CONSENT FORM**. I voluntarily consent to the collection of blood, urine or OMT samples for the purpose of testing to determine if HIV antibodies are present and the disclosure of the test results as described above.

Name of Proposed Insured	Signature of Proposed Insured	Date
Birth date	State of Residence	
Name of Medical Professional or Company Agent Collecting Sample	Signature of Medical Professional or Company Agent	

Notification of Test Results

To be completed at time of application or when a Medical Professional or company agent obtains sample.

You may choose to receive the test results directly or to designate below another person to whom the results should be sent:

PLEASE SEND MY TEST RESULTS TO:

Name _____

Address _____

City _____ State _____ Zip Code _____

WHITE – HOME OFFICE

CANARY – PROPOSED INSURED

PINK – AGENT/EXAMINER