



**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b. Had your application for life, health, or accident insurance rejected, rated up, restricted, postponed or withdrawn?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>	<b>YES</b>	<b>NO</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>	<input type="checkbox"/>	<input type="checkbox"/>
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. <b>Current occupation:</b> _____  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. <b>Avocation Question:</b> <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).

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

<b>6. Please indicate applicant's build and family history below:</b>		<b>Please provide the complete name and address of your primary care physician:</b> 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)
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: _____	

<b>Family History</b>	<b>AGE</b>	<b>Living State of Health</b>	<b>AGE</b>	<b>Not Living Cause of Death</b>	<b>8. Examiner Questions:</b> 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> _____
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**  
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

Form HL-12536-2  
Printed in U.S.A.

**HARTFORD LIFE INSURANCE COMPANIES**  
National Service Center  
P.O. Box 59179

VA



# Hartford Life

## 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

WHITE - HOME OFFICE

CANARY - PROPOSED INSURED

PINK - AGENT/EXAMINER

**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

Form HL-12536-2  
Printed in U.S.A.

**HARTFORD LIFE INSURANCE COMPANIES**  
National Service Center  
P.O. Box 59179

VA



# Hartford Life

## 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

WHITE - HOME OFFICE

CANARY - PROPOSED INSURED

PINK - AGENT/EXAMINER