PERSONAL HEALTH APPLICATION

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Please completely fill out **Section 1 and Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1: Employer Details *(to be completed by Employer)*

PLEASE PRINT CLEARLY

Employer Name: State Of Iowa	Policy Number: 675831
Division *(if applicable):*	
Employer Mailing Address (Street, City, State, Zip Code):	
Benefits Contact Name (First, Last):	
Benefits Contact Email Address:	Benefits Contact Phone: ( ) -

Section 2: Employee Details *(to be completed by Employer)*

PLEASE PRINT CLEARLY

Employee Name (First, MI, Last):

Base Annual Earnings*:	Social Security Number: - -	Date of Hire (mm/dd/yyyy): / /

* Base annual earnings as described in the contract with The Hartford.

Coverage Details

- Check the applicable box(es) in each row to reflect the applicant's current coverage and new election.
- Enter the amount of any **existing** coverage (including Guarantee Issue (GI)**) in **Current Coverage**. Please include the current amount of Employee Basic Life coverage even if the employee is not requesting Basic Life coverage at this time.
- Enter the amount of **Additional Coverage Requested** that requires medical underwriting.
- Enter the **Total Coverage Amount** that will be in force if the additional coverage requested is approved.
- If the applicant is enrolling after his/her initial eligibility period and does not have current coverage they will be responsible for all fees incurred during the medical underwriting process.

		Current Coverage (including GI Amount)	Additional Coverage Requested	Total Coverage Amount
	Life Insurance Coverage	*Enter all amounts as dollars. Include **Basic Life Current Coverage Amount** even if not requesting this coverage type.*		
☐	Employee Basic Life	$	$	$ 0.00
☐	Employee Supplemental or Voluntary Life	$	$	$ 0.00
	Disability Insurance Coverage	*Enter all amounts as dollars*		
☐	Long Term Disability			$0.00

** Guarantee Issue (GI) is the maximum amount of coverage, as defined in the contract with The Hartford, which does not require evidence of good health.

Employees: Please complete pages 2 thru 5. It should take you about 10 minutes to complete this form.

Applicant Section: Please answer all questions on this page completely and accurately and certify your answers on page 4.
Leaving information blank will result in delays and may result in your file being closed.

Section 3: Employee Information *(Complete even if employee is not applying for coverage)* **PLEASE PRINT CLEARLY**

First Name:	Last Name:	Social Security # : - -	
Home Mailing Address (Street, Apt. #):		City:	
State:	Zip Code:	Employer:	
Daytime Phone: ( )	Evening Phone: ( )	Height: ___Ft. ___In.	Weight:_____ lbs.
Gender: ☐ M ☐ F	Date of Birth: / /	Email Address:	

Section 4 – Medical Information *(to be completed only by applicants required to provide evidence of good health)*

If you can answer ***Yes*** to any of the Questions below, check the appropriate box and provide **additional details in Section 5.** If you are a **resident of one of the following states:** Connecticut, Florida, Kentucky, Maine, Maryland, Minnesota, New York, North Carolina, Vermont, or Wisconsin then please go to the State Variable Question section on page 3 and answer or review the appropriate question for your state. **After you have read that information, proceed with completing this section**.

1. 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?	☐ Employee
2. Within the past 5 years, have you used any controlled substances, with the exception of those prescribed by your physician, received medical advice or sought treatment for drug or alcohol abuse, or been charged with operating a motor vehicle under the influence of drugs or alcohol?	☐ Employee
3. Are you currently undergoing any diagnostic testing for symptoms without a final diagnosis or resolution?	☐ Employee
4. Are you currently pregnant? If yes, what was your pre-pregnancy weight?_____ lbs.	☐ Employee
5. During the past 5 years have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune deficiency disorder?	☐ Employee

6. During the past 5 years have you been diagnosed with, treated for, treated with, or had any symptoms due to any of the following conditions or treatments listed below? **Please check all that apply:**

	Employee		**Employee**
Heart-Related Surgery or Heart Attack	☐	Crohn's Disease	☐
Stroke	☐	Kidney Failure/Dialysis	☐
Heart Disease (excluding high blood pressure & heart murmur)	☐	Hepatitis (excluding Hepatitis A)	☐
Blocked Arteries (including arteriosclerosis, atherosclerosis, aneurysm, or deep vein blood clot)	☐	Diabetes	☐
Chronic Obstructive Pulmonary Disorder (COPD)	☐	Knee Disorder, Injury, or Surgery	☐
Emphysema	☐	Back or Neck Disorder, Injury, or Surgery	☐
Adjustment Disorder	☐	Joint/Ligament Disorder, Injury, or Surgery	☐
Bipolar Disorder	☐	Osteoporosis or Osteopenia	☐
Depression (single episode)	☐	Multiple Sclerosis (MS)	☐
Depression (multiple episodes)	☐	Amyotrophic Lateral Sclerosis (ALS)	☐
Psychotic/Personality Disorders	☐	Muscular Dystrophy	☐
Other Mental/Nervous/Psychiatric Disorders (including Anxiety)	☐	Arthritis	☐
Cancer (excluding Basal Cell Carcinoma)	☐	Fibromyalgia	☐
Cirrhosis	☐	Chronic Fatigue Syndrome	☐
Ulcerative Colitis	☐	Sleep Apnea	☐

Employee: First Name_____ **Last Name**_____

Section 4 Continued: State Variable Questions

For residents of Connecticut, Florida, Kentucky, Maine, Maryland, Minnesota, New York, North Carolina, Vermont, and Wisconsin review or answer, where applicable, the question listed below instead of the corresponding question listed in the Medical Information section on **page 2**. Any "Yes" responses can be explained in the Additional Details section of this form. Once you have reviewed/answered these questions, please return to **Section 4** and proceed with completing the rest of the form.

Information to be Reviewed

Florida, Kentucky, and Maryland Residents- Please review this question prior to answering Question 6 in the Medical Information Section on Page 2:
Question 6: During the past 5 years have you been diagnosed with, treated for, or treated with any of the following conditions or treatments listed below? **Please check all of the conditions on page 2 that apply.**

Maine Residents- Please review this statement prior to answering the medical questions in Section 4 on Page 2:
You are not required to disclose whether you have been tested for HIV, if you have not developed symptoms of the disease AIDS or ARC, in your answer to any of the questions in the Medical Information section.

Minnesota Residents- Please review this statement prior to answering the medical questions in Section 4 on Page 2:
You need not disclose an HIV (aids virus) test which was administered: (1) to a criminal offender or criminal victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services.
Please review this question prior to answering Question 6 in the Medical Information Section on Page 2:
Question 6: During the past 5 years have you been diagnosed by a physician with, treated for, or treated with any of the following conditions or treatments listed below? **Please check all of the conditions on page 2 that apply.**

Questions to be Answered

Connecticut and Minnesota Residents: Do not answer Question 2 in the Medical Information section. Answer the following question below.
Question 2: Within the past 5 years, have you used any controlled substances, with the exception of those prescribed by your physician, received medical advice or sought treatment for drug or alcohol abuse, or been convicted of operating a motor vehicle under the influence of drugs or alcohol? ☐ **Employee**

Florida residents: Do not answer Question 5 in the Medical Information section. Answer the following question below.
Question 5: Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or had unexplained weight loss or enlarged lymph nodes?
☐ **Employee**

New York Residents: Do not answer Question 5 in the Medical Information section. Answer the following question below.
Question 5: During the past 5 years have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune deficiency disorder excluding HIV?
☐ **Employee**

North Carolina Residents: Do not answer Question 5 in the Medical Information section. Answer the following question below.
Question 5: Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? AIDS Related Complex (ARC) is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythamatosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.
☐ **Employee**

Vermont Residents: Do not answer Questions 3 or 5 in the Medical Information section. Answer the following questions below.
Question 3: Are you currently undergoing any diagnostic testing (excluding prior HIV related testing) for symptoms without a final diagnosis or resolution? ☐ **Employee**

Question 5: Have you been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician?
☐ **Employee**

Wisconsin Residents: Do not answer Question 3 in the Medical Information section. Answer the following question below.
Question 3: Are you currently undergoing any diagnostic testing, excluding AIDS or HIV tests, for symptoms without a final diagnosis or resolution? ☐ **Employee**

Please proceed with completing the rest of the medical questions on Page 2 once you have completed/reviewed this page.

Employee: First Name_____ **Last Name**_____

Section 5: Additional Details: If you checked any box related to Questions 1 – 6, please provide details in the space below. If you need more space, please attach, sign and date an additional sheet. The Hartford may contact you for additional or missing information.

Question # or Condition	Applicant Name	Medications/ Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name, Address, and Phone #

Section 6: Health Question Certification Statement *(To be completed by all applicants)*

By checking this box: ☐ **Employee**

I hereby certify that I have reviewed each of the above questions and conditions.
I also certify that I have checked all of the questions and conditions that apply to my health history.

Section 7: Authorization *(To be reviewed by all applicants)*

New York Residents: I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford. I authorize The Hartford to give information about me to: its reinsurer(s); the Medical Information Bureau, Inc.; any other insurance company to whom I may apply for Life or Health Insurance; or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application; or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires 24 months from the date of this application. I understand that a photocopy of this form is as valid as the original and that I have a right to receive a copy of this form upon request.

Residents of All States Except New York: I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford. I authorize The Hartford to give information about me to: its reinsurer(s); the Medical Information Bureau, Inc.; any other insurance company to whom I may apply for Life or Health Insurance; or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application; or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires 24 months from the effective date of my coverage or, if no coverage has been issued, one (1) year from the date of this application. I understand that a photocopy of this form is as valid as the original and that I have a right to receive a copy of this form upon request.

Additional Language for Maine Residents: This authorization excludes disclosure of the result of a test for HIV if the applicant has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS or ARC. I understand that my failure to sign this authorization may impair the ability of The Hartford to process this application or evaluate claims and may be a basis for denying this application or a claim for benefits.

Additional Language for Minnesota Residents: This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or criminal victim as a result of a crime that was reported to the police; (2) to a patient who received the services of Emergency Medical Services personnel at a hospital or medical care facility; or (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "Emergency Medical Personnel" includes individuals employed to provide pre-hospital emergency services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and would qualify for immunity under the Good Samaritan Law.

Employee: First Name_____ Last Name_____

Section 8: Certification (*To be reviewed by all applicants*)

Residents of All States: I hereby certify ("**represent" for Kansas residents)** that all statements and answers contained herein, are full, complete, and true to the best of my knowledge and belief.

Residents of All States Except New York: I also understand that any misrepresentation contained herein or relied upon by the company may be used to contest the validity of the coverage, within the contestable period if such misrepresentation materially affects acceptance of the risk. This information may be used by The Hartford for plan administration purposes to decide if the person(s) is/are eligible for coverage.

I understand that coverage will not become effective until The Hartford grants it's underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

I agree that this document and all its contents shall form a part of my request for group benefits.

Section 9: Fraud Statement *(To be completed by <u>all</u> applicants)*

Residents of All States Except California, Pennsylvania, and New York: 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 is guilty of a crime and may be subject to fines and confinement in prison.

California Residents: For your protection, California law requires the following to appear on this form: any person who knowingly presents a 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**.**

Pennsylvania Residents: 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 subjects a person to criminal and civil penalties.

New York Residents: 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.

Notice*:* To the best of their knowledge, an Applicant is required to notify The Hartford in writing of any changes in any applicant's medical condition between the date the Applicant signs this form and the date the coverage is approved.

_____ ____/____/____

Employee's Signature or Legal Representative/ Relationship to Employee **(Required)** — **Date Signed**

Please return the completed Employer and Employee sections to:
The Hartford, Medical Underwriting
P.O. Box 2999
Hartford, CT 06104-2999

After submitting this application, you can check your status on line at **www.TheHartfordAtWork.com.**

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**.**