



Evidence/Proof of Insurability for Disability Insurance

This form is for residents of AL, AK, AZ, AR, CA, CO, CT, DE, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MS, MT, NC, NE, NV, NH, ND, OH, OK, OR, PA, Puerto Rico, RI, SC, SD, TX, UT, VT, VA, WA, Washington DC, WV, & WY.

Instructions for Employer/Benefit Administrator:

1. Please complete Part 1 of the form as applicable to the plan(s) requiring evidence of insurability. Type or print clearly with blue or black ink. We cannot accept faxed or photocopied applications, applications completed in pencil, or customized applications that have not been approved by the EOI Department. Enrollment forms are not considered EOI Applications.
2. If a question or item of information requested is not applicable, please write in “none” or “no.”
3. Upon completion, please give to the employee for completion of Part 2.

Instructions for Employee/Member:

1. It is required that you be given the “NOTICE TO PROPOSED INSURED REGARDING MEDICAL INFORMATION BUREAU & INFORMATION PRACTICES,” located on page two of this form. Please read it carefully and keep it for your records.
2. Please complete Part 2 of the form. **Incomplete information will result in delays.** Type or print clearly with blue or black ink. We cannot accept faxed or photocopied applications, applications completed in pencil, or customized applications that have not been approved by the EOI Department. Enrollment forms are not considered EOI Applications.
3. If a question or item of information requested is not applicable, please write in “none” or “no.”
4. In the states of AZ, CA, ID, LA, NV, NM, TX, or WA, the law requires that if you are married, your spouse must be your beneficiary unless your spouse gives signed consent for another beneficiary. So if you name someone other than your spouse, then you must have your spouse sign this application as consent. Also, if you have designated an irrevocable beneficiary, and you name someone other than the irrevocable beneficiary, then his/her signature of consent is needed.
5. **If you make any changes to the application, please initial and date next to the change(s).**
6. Keep this portion of the form, and be sure to keep a copy of the completed application. Mail to:

The Hartford
Group Medical Underwriting
PO Box 2999
Hartford, CT 06104-2999

PAYROLL DEDUCTION AUTHORIZATION FOR GROUP DISABILITY INSURANCE

EMPLOYEE SIGNATURE: I desire to participate in the Group Disability insurance program as presented to me and hereby authorize my employer to make the necessary deduction from my wage or salary to pay my part of the premium.

Signature of Applicant/Employee	Date Signed
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EMPLOYER INSTRUCTIONS: Send this deduction authorization along with the original application to **THE HARTFORD**. When we have completed our underwriting of this applicant, the Payroll Authorization form will be returned to you and the Effective Date of the Employee’s coverage (if approved) will be indicated on this form. Begin payroll deduction in accordance with the effective date.

Name of Employee

Approved by (Authorized Company Representative)	Effective Date of Coverage
	STD: LTD:

Administered by:



Underwriting Company (herein called the “Company”): *

- CNA Group Life Assurance Company
- Continental Assurance Company
- Continental Casualty Company

**Applicant:
Please Read &
Detach**

**NOTICE TO PROPOSED INSURED REGARDING
MEDICAL INFORMATION BUREAU & INFORMATION PRACTICES**

In order to properly underwrite and administer your application for insurance coverage, the Company and The Hartford must collect certain information concerning your insurability. You are our most important source of information, but the Company and The Hartford may also contact other sources, including medical professionals and institutions, employers and other insurance companies. In certain instances, the Company and The Hartford may also need to conduct an investigative consumer report. This usually takes the form of a personal interview that is conducted with you in person or over the telephone. If an interview is conducted with someone other than you, the Company and The Hartford will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. All information regarding your insurability will be treated as confidential.

You have the right to be told about, and to see (and copy if you wish), items of personal information about you which appear in the files of the Company and the Hartford, including the nature and scope of information contained in investigative consumer reports. You also have the right to seek correction, amendment or deletion of information you believe to be inaccurate.

The Company and The Hartford may also make information in its files available to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

The Company and The Hartford may make a brief report regarding your insurability to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

* The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company, Hartford Life Insurance Company and CNA Group Life Assurance Company (pending state approval of name change to “Hartford Life Group Insurance Company”).

Administered by:



Underwriting Company (herein called the "Company"):

- CNA Group Life Assurance Company*
- Continental Assurance Company
- Continental Casualty Company

GROUP DISABILITY PROOF/EVIDENCE OF INSURABILITY

Complete ALL information. Incomplete information will result in delays. Type or print clearly with blue or black ink. Forward the original application to THE HARTFORD.

PART 1: EMPLOYER INFORMATION (MUST BE COMPLETED)

Long Term Disability (LTD); Policy Number: 83116904

Employer's Name LSU System – A& M - 1	Contact Name Michele Zeber	Phone Number 225-578-8397
Employer's Mailing Address 304 Thomas Boyd Hall	City Baton Rouge	State LA
	ZIP/Postal Code 70803	<input type="checkbox"/> Late Enrollee <input type="checkbox"/> Other:

PART 2: EMPLOYEE APPLICATION FOR COVERAGE

(TO BE COMPLETED BY EMPLOYEE)

Benefit option:		%	Class:	
1. Employee's Name	Gender	Date of Birth	State of Birth	Social Security #
Residential Street Address	City	State	Zip Code	Home Phone
				Height
				Ft. In. Lbs.
2. Occupation	Work Phone Number	Date of Full-Time Employment	Number of hours in a regular workweek?	Monthly Salary
Duties:	(b) Are you currently performing the duties of your occupation for a regular workweek? (If NO, explain in remarks section below) <input type="checkbox"/> YES <input type="checkbox"/> NO			
3. Primary Beneficiary Name*	Social Security Number		Relationship	
Beneficiary Street Address	City	State	Zip Code	

* A signature of consent is needed of (1) any irrevocable beneficiary OR (2) your spouse if you are a resident of AZ, CA, ID, LA, NV, NM, TX, or WA and you name someone else as beneficiary; if so, please have your spouse or irrevocable beneficiary sign the bottom of this form.

4. (a) What other disability income insurance are you now carrying or have an application or reinstatement pending for? (If none, please indicate)

COMPANY	BENEFIT AMOUNT(S)	ELIMINATION PERIOD ACCIDENT/SICKNESS	MAXIMUM BENEFIT PERIOD ACCIDENT/SICKNESS

(b) Have you ever had any disability income insurance postponed, rated, waived, declined, canceled or had reinstatement refused? If YES, give dates, company name and reason in the remarks section below. YES NO

Remarks: Questions 2b and 4b (if additional space is needed, use a signed, dated separate sheet.)

5. To the best of your knowledge and belief, have you within the last 10 years been medically treated or medically diagnosed for any of the following:

- (a) Epilepsy, paralysis, or any nervous, mental or emotional disorder? YES NO
- (b) Abnormal blood pressure, heart attack, heart murmur, stroke; any other blood, heart, or circulatory disorder? YES NO

- (c) Any lung or respiratory disorder? YES NO
- (d) Ulcer of the stomach or duodenum; any rectal, liver or gall bladder disorder, or any other digestive disorder? YES NO
- (e) Kidney or any urinary disorder, albumin, pus or sugar in urine, disorder of the prostate or genital organs? YES NO
- (f) Thyroid disorder, diabetes, gout, any eye or ear disorder, any discolored areas or lesions of the skin or mouth? YES NO
- (g) Arthritis, rheumatism, any disorder of the back, spine, bones, muscles or joints? YES NO
- (h) Cancer, tumor, growth, enlarged lymph nodes or any skin disorder? YES NO
- (i) Alcoholism, drug dependency or substance abuse? YES NO
- (j) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? YES NO

6. **When and why** did you last consult a doctor? _____
- (a) What were you told about the findings? _____
- (b) What Treatment and drugs were prescribed? _____
- (c) Are you still under treatment? _____ YES NO

7. To the best of your knowledge and belief, have you ever had any physical impairment, deformity, sickness, operations, injuries or check-ups during the past 5 years other than admitted in questions 5 or 6? YES NO

8. To the best of your knowledge and belief, are you pregnant at this time? YES NO

9. **If any answer to questions 5, 6 or 7 is YES, complete the following.** (If additional space is needed, use a signed, dated separate sheet.)

QUESTION #	MEDICAL CONDITION	DATES From – To	RESULTS	DOCTOR OR HOSPITAL NAMES & ADDRESSES
		–		
		–		
		–		

YOU MUST SIGN BOTH THE ACKNOWLEDGMENTS SECTION (PART 3) AND THE AUTHORIZATION SECTION (PART 4) IN ORDER FOR US TO PROCESS YOUR APPLICATION

PART 3: ACKNOWLEDGEMENTS

I ACKNOWLEDGE having received and read, or had read to me, the Notice To Proposed Insured Regarding Medical Information Bureau & Information Practices (where applicable).

I CERTIFY that I have read, or had read to me, the completed application. I UNDERSTAND AND AGREE that the statements in this application are complete and true to the best of my knowledge and belief and that this application will form a part of the contract of insurance.

I UNDERSTAND that the statements in this application are considered representations and not warranties, and that the insurance for which I am applying, if issued, shall be based on these statements. If this application is accepted, I understand that my insurance will take effect in accordance with the provisions of the insurance contract.

Caution Notice: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind your coverage, subject the incontestability provisions in the insurance contract.

Fraud Warning Notice: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Date

Employee's Signature

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***PLEASE ALSO SIGN PAGE 5 ***

YOU MUST SIGN BOTH THE ACKNOWLEDGMENTS SECTION (PART 3) AND THE AUTHORIZATION SECTION (PART 4) IN ORDER FOR US TO PROCESS YOUR APPLICATION

PART 4: AUTHORIZATION TO OBTAIN INFORMATION

Administered by: Underwriting Company (herein called the "Company"):



- CNA Group Life Assurance Company *
- Continental Assurance Company
- Continental Casualty Company

"Information Provider" as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, clearinghouse, insurance or reinsuring company, (including affiliated insurance companies of the Company), agent, broker, service provider, Medical Information Bureau, Inc. (MIB), credit bureau or other consumer reporting agency, employer or the Veterans Administration.

"Information" received from an Information Provider may include advice, diagnosis, prognosis, treatment or care of any physical or mental condition concerning me, including information about HIV or AIDS, drug or alcohol abuse or mental illness (except psychotherapy notes) and/or financial, consumer report, or any other non-medical information or personal information concerning me.

I AUTHORIZE any Information Provider to give the Company and The Hartford any and all Information regardless of any previous restriction or limitation on disclosure of such Information. In order to expedite my request, I further authorize an Information Provider (except MIB) to release Information to The Hartford and The Company's agents, brokers, service providers, its reinsurers, or any other third party retained by the Company and The Hartford to collect and transmit such Information.

I UNDERSTAND that the Information obtained by use of this Authorization is at my request and will be collected by the Company and The Hartford to determine eligibility for insurance. I understand that this Authorization shall remain valid for twenty-four months from the date shown below. I understand that if I do not sign this Authorization, the Company and The Hartford may not accept my application for insurance. I also understand that my refusal to sign this Authorization does not affect my ability to receive treatment from my physician or other health care provider.

I UNDERSTAND that the Company and The Hartford may maintain or have access to personal information acquired separately through any of my previous insurance applications with the Company and The Hartford or its affiliates for insurance even in instances where insurance was not placed with me. I authorize the Company and The Hartford to use or disclose such information in consideration of my current application for insurance.

I UNDERSTAND that I may revoke this Authorization at any time by providing written notice to the Company and The Hartford, except: (i) to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation, or (ii) to the extent that this authorization was provided as a condition of obtaining insurance coverage and other law provides the Company and The Hartford with the right to contest a claim for coverage under the policy or the insurance coverage under the policy itself.

I UNDERSTAND that Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I UNDERSTAND that I may request to receive a copy of this Authorization and I agree that a photographic copy of this Authorization shall be as valid as the original.

_____ **Date**

_____ **Employee's Signature**

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ORIGINAL TO THE HARTFORD GROUP BENEFITS UNDERWRITING; COPY TO APPLICANT