THE HARTFORD

Employer Group Benefits Coverage Information

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.

Employees: Please completely fill out the **Applicant Information section on the 2nd page** even if you are not applying for coverage.

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

Employer Name: Bishop Of Charleston	Policy Number: 681494
Employer Mailing Address (Street, City, State, Zip Code): 901 Orange Grove Road, Charleston, SC 29407	
Division/Location/Subsidiary with Mailing Address *(if applicable):*	
Benefits Contact Name (First, Last): Matthew Wilson	
Benefits Contact Email Address: mwilson@charlestondiocese.org	Benefits Contact Phone: 843-261-0425

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

Employee Name (First, MI, Last):	Employee ID:
Base Annual Earnings* * As described in the contract with The Hartford	Date of Hire (mm/dd/yy):

Life Insurance Coverage Requested: *GI is the maximum amount of coverage as defined in the contract with The Hartford that does not require EOI.

	Current Coverage: Amount of coverage you currently have prior to completing this PHA including Guaranteed Issue (GI) if any*.	**Plus (+)**	**Additional (New) Coverage Requested:** The coverage amount above the "current coverage", that requires Evidence of Insurability (EOI)*.	**Equals (=)**	**Total Coverage:** Current Coverage plus Additional Amount equals the total coverage.
Employee Basic Life:	$ N/A	+	$ N/A	=	$
Employee Supplemental or Voluntary Life:	$	+	$	=	$
Spouse Basic Life:	$ N/A	+	$ N/A	=	$
Spouse Supplemental or Voluntary Life:	$	+	$	=	$

Child Supplemental or Voluntary Life Requested:

Check Yes if Employee is requesting Child Life coverage that is subject to EOI	☐ Yes, EOI is required	Indicate the number of Child(ren) applying: N/A

Disability Insurance Coverage Requested:

☐ Yes, EOI is required for Short Term Disability
☐ Yes, EOI is required for Long Term Disability

Employee: First Name _____ Middle Initial ____ Last Name _____

EVIDENCE OF INSURABILITY APPLICATION

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155

Applicant Information: please print clearly and completely.
If there are more than three Applicants, please provide the information on a separate sheet of paper.
Abbreviations: Employee = EE Spouse = SP Child = CH

	First Name	Last Name	Social Security #	Gender	Height (ft./in.)	Weight (lbs.)*	Date of Birth (mm/dd/yyyy)
Employee				☐ Male ☐ Female ☐ Other			
Spouse				☐ Male ☐ Female ☐ Other			
Child				☐ Male ☐ Female ☐ Other			

* If currently pregnant, please provide pre-pregnancy weight

Employee	Street Address		Cell Phone	
	City		Other Phone	
	State, Zip Code		Email Address	

Spouse	Street Address		Cell Phone	
	City		Other Phone	
	State, Zip Code		Email Address	

☐ Spouse's Address is the same as the Employee's

Child	Street Address		Cell Phone	
	City		Other Phone	
	State, Zip Code		Email Address	

☐ Child's Address is the same as the Employee's

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Employee: First Name _____ Middle Initial ____ Last Name _____

Medical Information			
Each Applicant must answer each of the following questions to the best of their knowledge and belief. A Legal Guardian is required to answer each of the questions for minor children. If you have more than 1 Child, specify which Child(ren) the answer applies to on a separate sheet of paper. **Please mark Yes/No response clearly and ensure response does not overlap in boxes.**	**EE**	**SP**	**CH**
Within the past 5 years, have you been diagnosed with or treated by a licensed medical physician for Acquired Immune Deficiency Syndrome (AIDS) or an AIDS defining illness?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you currently pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 consecutive work days due to a disability, injury, or Illness?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 5 years, have you used any illegal drugs or narcotics, with the exception of those taken as prescribed by your physician?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 5 years, have you been diagnosed or treated by a licensed medical professional for drug or alcohol abuse (excluding support groups)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or non-prescribed drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 5 years, have you been convicted of operating a motor vehicle while under the influence of drugs or alcohol?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Within the past 5 years, have you had a suicide attempt, or suicidal ideation?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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Employee: First Name _____ Middle Initial ____ Last Name _____

Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for:

***Mark Yes/No response clearly and ensure response does not overlap in boxes.**

	EE	SP	CH		EE	SP	CH
Coronary Artery Disease, Heart Failure, Cardiomyopathy, Heart Enlargement, Heart Surgery or Heart Attack, Congenital Heart Defect, Abnormal Heartbeat, Heart Infection, and/or Heart Valve Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Cancer, Malignancy, Leukemia, Lymphoma, Hodgkin's' Disease, Non-Hodgkin's Disease, Blood Cancer, Myeloma, Multiple Myeloma, and/or Carcinoid (Do not check "YES" for history of Basal Cell Carcinoma) If "YES," Date of Diagnosis: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure If you checked "YES" to High Blood Pressure, have you had a change in medication within the last 6 months?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	Osteoarthritis, Rheumatoid Arthritis, Psoriatic Arthritis, Gouty Arthritis or any Disease, Injury or Surgery of Ligaments, Tendon, Cartilage or Joints including Knee, Back, Spine, Shoulder, Hip, Ankle, Elbow, and/or Hand/Wrist	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Blocked Arteries, Carotid Artery Disease, Peripheral or Cerebral Vascular Disease, Arteriosclerosis, Atherosclerosis, and/or Aneurysm	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Chronic Fatigue Syndrome, and/or Fibromyalgia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Brain Tumor, Stroke, Cerebral/Subarachnoid Hemorrhage, Arteriovenous Malformation, Traumatic Brain Injury (TBI), and/or Transient Ischemic attack (TIA)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Systemic Lupus, Connective Tissue Disease, Glomerulonephritis, Nephrotic Syndrome, Mixed Connective Tissue Disease, Scleroderma, Crest Syndrome, Sjogren's Syndrome, Cholangitis, and/or Primary Sclerosing Cholangitis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Pancreatitis, Cirrhosis, and/or Hepatitis (Do not check "YES" for Hepatitis A)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema, Respiratory Failure, Pulmonary Fibrosis, and/or Interstitial Lung Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS), Alzheimer's Disease, Cognitive Impairment, Dementia, Parkinson's Disease, Muscular Dystrophy, and/or Paralysis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Type 1 or 2 Diabetes (do not check "YES" for history of pregnancy related diabetes or prediabetes)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Major Organ Failure and/or Transplant	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mood Disorder, Dysthymia, Adjustment Disorder, Depression, Generalized Anxiety Disorder, and/or Post Traumatic Stress Disorder (PTSD)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Ulcerative Colitis, Crohn's Disease, Barrett's Esophagus, and/or Esophageal Varices	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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Employee: First Name _____ Middle Initial ____ Last Name _____

	EE	SP	CH		EE	SP	CH
Psychotic, Personality, Bi-Polar, Schizophrenia, and/or Eating Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Chronic Kidney Disease, Kidney Failure or Dialysis, and/or Polycystic Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Aplastic Anemia, Sickle Cell Anemia, Hemolytic Anemia, and/or Thalassemia Major	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Glaucoma, Iritis, Scleritis, Macular Degeneration, Optic Neuritis, Retinal Detachments, Retinopathy, and/or Meniere's Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Notice, Authorization, and Consent

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company ("The Company"), may contact you to ask additional questions or request additional information as authorized by you. In addition, The Company may obtain information from other sources and copies of medical records that you have authorized us to review**.**

I, an undersigned applicant, authorize The Company to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, including voicemail, or through electronic messaging applications, at the address, or telephone number, or through other communications as identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request additional information including a paramedical exam.

In addition to the information that I have provided on this application, I authorize The Company to use information about me obtained from Company claim files, insurance applications, claims information, and other medical information I or my physician(s) have previously submitted to The Company. I further authorize my employer, any health or benefits plan, physician, medical professional, hospital, clinic, laboratory, pharmacy or pharmacy benefits manager, medical data reporting agency, Motor Vehicle Department, Criminal Record Authority, Background Reporting Agency, that possesses my personal health information ("PHI") or other personal information, including copies of records concerning physical or mental illness (but excluding psychotherapy notes), diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding genetic testing), driving record, criminal history, or other relevant background information to furnish such PHI or other personal information to The Company or its representative.

The Company may only use information disclosed under this authorization that is relevant to underwrite this or any other insurance application to The Company during the twenty-four (24) months from the date signed below, at any time to aid in the detection of fraud, to respond to regulatory or similar complaints, and for internal research purposes.

I authorize The Company to disclose the PHI or other personal information in its files to its reinsurer(s) and affiliates, other insurance companies and their affiliates, other persons, representatives and/or organizations performing functions on behalf of the Company and their affiliates, my employer, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me that relates to this application and that such requested information and the identity of the source of the information shall be released to me or, in the case of medical information, to a licensed medical professional of my choice.

This authorization shall be valid for twenty-four (24) months from the date signed below. I understand that I am entitled to receive a copy of this authorization upon request. This authorization may be revoked upon written request to The Company, and will not remain valid beyond the date the revocation is received by The Company. I understand the revocation may be a basis for denying my insurance application, and that it does not alter The Company's right to use the application for purposes of determining misrepresentation once coverage has been issued.

I have received and read a copy of the Notice of Insurance Information Practices.

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Employee: First Name _____ Middle Initial ____ Last Name _____

Fraud

Please read the statement that applies to your state of residence and sign this application.

For residents of AK, AZ, AR, CT, DE, GA, GU, HI, ID, IL, IN, IA, KS, LA, MA, MI, MN, MS, MO, MT, NE, NV, NH, NC, ND, OH, OK, OR, RI, SC, SD, TX, UT, VT, VI, WV, WI, or WY: 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.

Confirmation

I hereby represent that I have reviewed the above questions and that all statements and answers contained herein are full, complete, and true to the best of my knowledge and belief. I agree to notify The Company in writing of any changes to my medical condition between the date I send this form and the coverage is approved.

This application will be made a part of the Policy.

_____	____/_____/_____	_____	____/_____/_____
Employee Signature	**Date Signed**	**Spouse Signature**	**Date Signed**

_____	____/_____/_____
Child Signature (Parent/Legal Guardian of the Child is required to sign when submitting dependent Evidence of Insurability on a minor child.)	**Date Signed**

Please mail the completed **Employer Group Benefits Coverage Information page** and **Evidence of Insurability application** to:

The Hartford, Medical Underwriting

P.O. Box 2999

Hartford, CT 06104-2999

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.

Questions? Call 1-800-331-7234

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Employee First Name: **Last Name:**

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza, Hartford, CT 06155

Authorization to Disclose Protected Health Information
To Be Used To Determine Eligibility for Group Life and/or Disability Income Coverage

I have applied for insurance under a Group Life andlor Disability Policy issued by Hartford Life and Accident Insurance Company ("The Hartford"). To assess whether I am eligible for this insurance, and for the additional purposes listed below, The Hartford may require that I authorize disclosure of a copy of my Health Information. Although Group Life and Disability Income Coverage are not subject to the requirements of HIPAA, this authorization is intended to comply with the requirements under Section 164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), effective April 14, 2003.

I authorize any: health plan, physician, medical or health practitioner, counselor, therapist, hospital, clinic, other medical or medically-related facility, or other health care provider who has provided treatment, payment, or services to me or on my behalf within the last 10 years; insurance company; or reinsurance company, with which I have had coverage, and the Medical Information Bureau, Inc. (MIB), (collectively, Releasers); to disclose to The Hartford and its service providers, Health Information about me.

The Hartford and its service providers may disclose my Health Information to The Hartford's agents, employees, representatives and service providers. My Health Information means my entire medical file, including but not limited to: x-rays; photocopies of medical records, prescription information, medical histories, physical, mental or diagnostic examinations, and treatment notes, that relate to: 1) Pre- existing or current illnesses, sicknesses, disease, disabilities, disorders, accidents, injuries, or any other health conditions, 2) Confinements in hospitals, medical facilities, or medical clinics, 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners, 4) Drug use, alcohol use, mental health, HIV/AIDS or sexually transmitted disease information protected by state or Federal Law, 5) Counseling or therapy. Health information also means information on the diagnosis and treatment of mental illness, but excludes psychotherapy notes as defined by HIPAA. I understand that the MIB will only disclose my Health Information to The Hartford.

The Hartford will use my Health Information obtained pursuant to this Authorization to underwrite my request for coverage; make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to any coverage I have applied for with The Hartford.

By signing this Authorization, I acknowledge and agree:

- That any agreements I have made to restrict disclosure of my Health Information do not apply to this Authorization;
- That I am authorizing the Releasers to release and disclose my Health Information, as described above, without restriction. By signing this Authorization, I acknowledge that I understand the following:
- That my Health Information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the Releasers' knowledge.
- That The Hartford only will use my Health Information to underwrite my request for coverage; make eligibility, risk rating, policy issuance, and enrollment determinations; obtain reinsurance; and conduct legal and business activities that relate to coverage I have applied for with The Hartford.
- That if 1) I refuse to sign this Authorization to release my entire medical file; or 2) if this Authorization is altered by me in any way, The Hartford may not be able to process my application for coverage.
- That, if 1) The Hartford denies my request for coverage; and 2) this denial is based, in whole or in part, on health information obtained in connection with this Authorization; The Hartford will not release this information to me unless otherwise authorized by the Releasers, including my physician or other medical professionals that disclosed such information to The Hartford unless required by law.
- That, if necessary, The Hartford will send this Authorization to Releasers authorized to release health information about me.
- That The Hartford will also provide me with written notice of Releasers to which The Hartford sends my Authorization.
- That I have a right, at anytime, to revoke this Authorization. To do so, I must send a written request directly to such Releasers. My revocation will not be effective: to the extent that action has been taken in reliance upon this authorization; or, The Hartford otherwise has the right: to contest the policy; or a claim under the policy.
- That this Authorization will expire 24 months from the effective date of my coverage or if no coverage has been issued, 24 months from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original.
- That I am entitled to a signed copy of this Authorization.

Applicant Name
(First, MI, Last)

Applicant Type
(Employee/Spouse)

Signature Date
(MM/DD/YYYY)

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Employer Name: Bishop Of Charleston