



APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

To be completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM)

Section I - Personal Data

Name: (Last, First, Middle Initial)		Social Security Number:	Group Number: GLT 395187
Address: (Street, City, State & Zip Code)			Telephone Number: ()
Date of Birth:	Height:	Weight:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Spouses Date of Birth:	Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Dependent Children:	
List names and dates of birth of unmarried children who have not finished High School:			

Section II - Employment Data

Name of Your employer: Northwest Airlines	Name of Your Immediate Supervisor/Manager:	Telephone Number: ()
Occupation: (Classification)	Date of accident or date symptoms first appeared:	
Date you were partially or totally disabled:	I returned to work on a limited basis: <input type="checkbox"/> Yes <input type="checkbox"/> No	I returned to work on a full time basis: <input type="checkbox"/> Yes <input type="checkbox"/> No
Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you filed, or do you intend to file a Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, status of claim: <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Pending		
Were you employed in other occupations prior to becoming disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Section III - Claim Data

Describe how and where the accident occurred or describe the onset and nature of your illness:	
What were your first symptoms?	Date you were first treated for your illness or injury:
Name of Hospital or Clinic:	Address of Hospital or Clinic: (Street, City, State & Zip Code)
Name of Physician:	Address of Physician: (Street, City, State & Zip Code)
Have you ever had the same or a similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who were you treated by?	

Section IV - Other Income Data

	Source of Income	Amount	Date filed	Date began	Date terminated
<input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security/Retirement (Disability or Retirement)	\$ _____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pension/Retirement (Normal, early or Disability)	\$ _____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Workers' Compensation	\$ _____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	NWA Benefit Accrual	\$ _____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Income from other employment	\$ _____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent and Total Disability	\$ _____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sick Leave	\$ _____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Salary Continuance	\$ _____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Short Term Disability	\$ _____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	State Disability	\$ _____	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	\$ _____	_____	_____	_____

Please read the statement that applies to your residence and sign the bottom of the page.

For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Virginia, Puerto Rico and District of Columbia: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** (In Oregon, a fraudulent insurance act may be a crime.) The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

For residents of New Jersey, Arkansas, and New Mexico: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of Pennsylvania: 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.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading information to an Insurance Company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF CALIFORNIA: 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."

For residents of Louisiana: 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.

For residents of New York: 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.

For residents of Puerto Rico: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For residents of Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

X _____
Signature of the Employee

X _____
Date

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION



To: Any health care provider, employer, benefit plan, insurer, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to The Hartford¹ a complete copy of any and all of the following personal or privileged information, records or documents relative to:

Insured's Name (*Please print*) _____ Date of Birth _____ Last 5 Digits of Social Security Number _____

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, and payment records; academic transcripts; and information concerning Social Security benefits, including, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits under my employer's benefit plan. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

I ALSO UNDERSTAND that once My Information has been disclosed to The Hartford, as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. I authorize The Hartford to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; e) matters relating to its workers' compensation arrangements; or f) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related my claim; (vi) to my employer's workers' compensation insurance carrier or administrator; (vii) as may be lawfully required; or (viii) as may be necessary to prevent or detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian _____ Relationship to Insured (*if signed by Guardian*) _____ Date _____

¹ The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and its administrative services company Hartford-Comprehensive Employee Benefit Service Company, and any of their parents, affiliates, subsidiaries and/or third-party contractors. Also as used herein, The Hartford provides insurance or claim administration services to my employer's employee welfare benefit plan(s).