# Children with Disabilities Eligibility Form

THE HARTFORD

Instructions to Group Policyholder:

1. Request for insurance must be submitted within 31 days* of the first to occur of: 1) becoming eligible for insurance or 2) termination of insurance due to the maximum age limit of dependent children as provided under your plan.
2. Upon completion by the employee and yourself, forward this form to the attending physician for the completion of his statement. He, in turn, should send the form to:
   Attention: Medical Underwriting, The Hartford, P.O. Box 2999, Hartford, Connecticut 06104-2999
3. You will be notified whether the insurance is approved.

*120 days if the policy is delivered in the State of Indiana

Name of Group Policyholder *(Employer)* _____ Policy Number _____

Employee Name _____ Social Security Number _____

Employee Address _____ Home Telephone Number (___) _____

Employment Date _____ Effective Date of Coverage _____ Total Coverage Amount Requested _____

Dependent's Effective Date of Coverage, if applicable _____

Last Date on which the Dependent attended school on a full time basis _____

This is to certify that _____ _____
Name of Dependent Child Birth Date

(1) is my unmarried child, (2) is mentally or physically incapable of earning his own living, (3) became so incapable prior to the limiting age for coverage of children under this policy and (4) is primarily dependent upon me for support and maintenance.

The nature of the disability is _____

_____; and it commenced _____

With respect to the above named child, I hereby request insurance which would: 1) otherwise not be available due to exceeding the limiting age for dependent children or 2) otherwise terminate due to attainment of the limiting age under the group policy.

I understand that on the part of the Insurance Company no liability for claim exists with respect to any period of time prior to the receipt and approval of this form by The Hartford, or its representatives.

The Hartford is authorized to contact my child's attending physician to obtain necessary information concerning my child's incapacity.

_____ _____
Signature of Group Policyholder *(Employer)* Signature of Employee

_____
Date

**Attending Physician's Statement** *(to be completed at employee's expense)*

Diagnosis, Concurrent Condition, and Prognosis:

Physician _____ _____ _____ (  ) _____
Name *(Please print.)* Signature Degree Telephone

Full Address _____
( Street, City or Town, State & Zip Code)

**For Home Office Use Only**

☐ Approved for Coverage By: _____

☐ Declined for Coverage Date: _____

Claim Dept. Follow-up Recommendation

☐ Frequent *(Condition expected to change)*

☐ Infrequent