

Personal Health Application PA-9597 Employer Guide*

A COMPLETED FORM SAVES YOU TIME

A completed form is required before The Hartford can reach a decision about coverage. Missing information will result in extra phone calls, correspondences, delays, or even an application being closed.



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.		
Section 1: Employer Details (to be completed by Employer)		
PLEASE PRINT CLEARLY		
Employer Name:	Policy Number:	
Employer Mailing Address (Street, City, State, Zip Code):		
Division/Location/Subsidiary with Mailing Address (if applicable):		
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):	Date of Hire (mm/dd/yyyy): / /	
Base Annual Earnings*:	Coverage Effective Date* (mm/dd/yyyy): / /	
* As described in the contract with The Hartford		
Life Insurance Coverage Requested		
<ul style="list-style-type: none"> • Enter the dollar amount of Current Life Coverage, including Guarantee Issue (GI)*. Please include Employee Basic Life coverage even if the employee is not requesting coverage at this time • Enter the dollar amount of Life Coverage Subject to Evidence of Insurability (EOI) 		
* GI is the maximum amount of coverage as defined in the contract with The Hartford that does not require EOI		
	Current Life Coverage, including GI	Life Coverage Subject to EOI
Employee Basic Life	\$	\$
Employee Supplemental or Voluntary Life	\$	\$
Spouse Basic Life	\$	\$
Spouse Supplemental or Voluntary Life	\$	\$
Child Supplemental or Voluntary Life		
<ul style="list-style-type: none"> • Check Yes if employee is requesting Child Life coverage that is subject to EOI <input type="checkbox"/> Yes, EOI is required • Indicate the number of children applying: _____ 		
Disability Insurance Coverage Requested		
<ul style="list-style-type: none"> • Check Yes if employee is requesting Short Term and/or Long Term Disability coverage that is subject to EOI 		
Short Term Disability	<input type="checkbox"/> Yes, EOI is required	
Long Term Disability	<input type="checkbox"/> Yes, EOI is required	

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Enter legal company name (no initials or abbreviations), policy number and all company information. **Note:** Division (if applicable) is a key trigger for missing information and will extend processing time.

Enter the employee's name, date of hire, base annual earnings and coverage effective date.

Check Yes if Child Life coverage is subject to EOI. No need to enter dollar amounts.

Check Yes if STD or LTD is subject to EOI. No need to enter dollar amounts.

Enter dollar amounts (not salary multiples) for Life coverage.

Include Employee Basic Life current coverage amount even if not requesting this coverage type.

Enter Employee and/or Spouse Current Life Coverage amounts, including GI. If no current coverage, enter 0 (zero).

Enter Employee and/or Spouse Life Coverage amounts subject to EOI.

Refer to your employee records for Life coverage amounts. Employee records are your property and are not on file with The Hartford's Medical Underwriting Department.

Read your Policy Contract carefully for your company's terms, requirements and exceptions.

*Guide to be used when submitting a Personal Health Application in all states using the new PA-9597 version

THREE MOST COMMON REASONS TO REQUIRE A PERSONAL HEALTH APPLICATION

A Late Entrant

- Every employee has an eligibility period for enrolling him or herself or a spouse or child, or for increasing coverage. It is usually 31 days from the date of a key event such as date of hire, date of a new marriage, or the birth or addition of a child. Your Policy contract will define the length and terms of your particular eligibility period.
- A Late Entrant is an employee, spouse or child* who did not elect coverage during the initial eligibility period.
- A Late Entrant is generally responsible for paying for all costs associated with medical evaluation, including physical exams and tests, if they are required by The Hartford.

Over the Guaranteed Issue Limit

- Applicants who apply during their initial eligibility period are generally guaranteed a certain amount of insurance without submitting evidence of good health. Your Policy Contract specifies these guaranteed amounts of "Guaranteed Issue Limits" for classes of employees, and for spouses and dependents.
- Anyone whose coverage request exceeds the Guaranteed Issue Limit in any amount, or for any reason, must complete a Personal Health Application in order to qualify for the excess coverage.
- Your Policy Contract also specifies rules that apply.
- Enrolling as a Late Entrant automatically nullifies a guaranteed amount, e.g. even if a requested coverage amount is within the Guaranteed Issue Limit, an applicant who is a Late Entrant, must complete the Personal Health Application in order to qualify for the requested amount

Opted Up to a Higher Level of Coverage

- Opting up to a higher level of coverage means going from 1-times Annual Earnings to 2-times Annual Earnings (or 3-times or more). An opt-up request after the initial eligibility period requires a Personal Health Application. However check your Policy because some Policy Contracts may have alternate requirements.
- In addition to these general guidelines, please read your Policy Contract carefully for your company's terms and requirements.

*Children requesting a total of \$15,000 or less do not require medical underwriting.

WHICH PERSONAL HEALTH APPLICATION DOES MY EMPLOYEE REQUIRE?

- > All residents of any state except NY and CA use the PA-9597 (CW) PHA
- > All residents of CA use the PA-9597 (CA) PHA
- > All residents of NY use the PA-9597 (NY) PHA

After completing the Employer Group Benefits Coverage Information page, provide the entire form, including both the Employer and Employee sections, to your employee to complete.

Need help completing the form? Contact us at (800) 331-7234 Monday through Friday, 8 a.m. to 8 p.m. EST, or email us at medical.uw@thehartford.com.