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**GROUP  
BENEFIT  
PLAN**

**CALIFORNIA SHORT-TERM DISABILITY SAMPLE CONTRACT**



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A note on capitalization in this benefits booklet:

Capitalization of the first letter of a word or phrase not normally capitalized according to the rules of standard punctuation (Weekly Earnings, for example) indicates a word or phrase that is defined in the DEFINITIONS section, or that refers back to an item found in the Schedule of Benefits.

PS-M-73

**INSURER INFORMATION NOTICE**

**NOTICE REQUIREMENT**

**IF YOU HAVE A COMPLAINT, AND CONTACTS BETWEEN YOU AND THE INSURER OR AN AGENT OR OTHER REPRESENTATIVE OF THE INSURER HAVE FAILED TO PRODUCE A SATISFACTORY SOLUTION TO THE PROBLEM, THEN YOU MAY CONTACT:**

**STATE OF CALIFORNIA INSURANCE DEPARTMENT  
CONSUMER COMMUNICATIONS BUREAU  
300 SOUTH STREET, SOUTH TOWER  
LOS ANGELES, CA 90013**

**1-800-927-HELP**

**THE HARTFORD'S ADDRESS AND TOLL-FREE NUMBER IS:**

**THE HARTFORD GROUP BENEFIT'S DIVISION  
POLICYHOLDER SERVICES, P.O. BOX 2999  
HARTFORD, CT 06104-2999  
TELEPHONE: 1-800-572-9047**



**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
Hartford, Connecticut  
(Herein called Hartford Life)

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**CERTIFICATE OF INSURANCE**

Under  
**The Group Insurance Policy**  
**as of the Effective Date**  
Issued by  
**HARTFORD LIFE**  
to  
**The Policyholder**

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This is to certify that Hartford Life has issued and delivered the Group Insurance Policy to The Policyholder.

The Group Insurance Policy insures the employee of the Policyholder who is named below and who:

- is eligible for the insurance;
  - becomes insured; and
  - continues to be insured;
- according to the terms of the Policy.

EMPLOYEE NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

The terms of the Group Insurance Policy which affect an employee's insurance are contained in the following pages. This Certificate of Insurance and the following pages will become your Booklet-certificate. The Booklet-certificate is a part of the Group Insurance Policy.

This Booklet-certificate replaces any other which Hartford Life may have issued to the Policyholder to give to you under the Group Insurance Policy specified herein.

**Richard G. Costello, Secretary**

**Thomas M. Marra, President**

## SCHEDULE OF INSURANCE

Final interpretation of all provisions and coverages will be governed by the Group Insurance Policy on file with Hartford Life at its home office.

Policyholder: ABC COMPANY  
Group Insurance Policy: GRH-123456  
Plan Effective Date: April 1, 2008

This plan of Short Term Disability Insurance provides You with short term income protection if You become Disabled from a covered injury, sickness, Mental Illness, Substance Abuse or pregnancy. Where used in this contract, the term Disabled or Disability shall mean Total Disability or Partial Disability as defined in the Definitions Section of the Certificate.

### **Must you contribute toward the cost of coverage?**

You [must/do not] contribute toward the cost of coverage.

### **Who is eligible for coverage?**

Eligible Class(es): [All Active Full-time Employees who are U.S. citizens or U.S. residents, excluding temporary and seasonal employees]

Full-time Employees: [30] hours weekly

The **Weekly Benefit** will be the lesser of:

- [60%] of your Weekly Earnings; or
- [\$1,000,]

reduced by Other Income Benefits.

[The **Minimum Weekly Benefit** will be \$25.]

### **The Maximum Duration of Benefits**

- [25 week(s) if caused by Accident and 25 week(s) if caused by Sickness.]

### **Benefits Commence** for Disability caused by:

- Accident: on the [8<sup>th</sup>] day of Disability
- Sickness: on the [8<sup>th</sup>] day of Disability

[Annual Enrollment Period: Determined by your Employer on a yearly basis]

### **When will You become eligible? (Eligibility Waiting Period)**

You are eligible on the later of either the Plan Effective Date or the date You enter an eligible class.

## ELIGIBILITY AND ENROLLMENT

### **Who are Eligible Persons?**

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

**When will you become eligible?**

You will become eligible for coverage on either:

1. the Plan Effective Date, if you have completed the Eligibility Waiting Period; or if not
2. the date on which you complete the Eligibility Waiting Period.

See the Schedule of Insurance for the Eligibility Waiting Period.

**[How do you enroll?**

To enroll you must:

1. complete and sign a group insurance enrollment form which is satisfactory to us; and
2. deliver it to the Employer.

If you do not enroll within 31 days after becoming eligible, the following limitations will apply to a later enrollment:

1. you must submit Evidence of Insurability satisfactory to us; and
2. you may not enroll until:
  - a) an Annual Enrollment Period; or
  - b) you have a Change in Family Status.

Any such enrollment must be made during the Annual Enrollment Period or within 31 days of the Change in Family Status.

The dates of the Annual Enrollment Period are shown in the Schedule of Insurance.

**What constitutes a Change in Family Status?**

A Change in Family Status means:

1. your marriage, or the birth or adoption of a child, or becoming the legal guardian of a child; or
2. the death of or divorce from your spouse; or
3. the death of or emancipation of a child.]

**[What is Evidence of Insurability?**

If you are required to submit Evidence of Insurability, you must:

1. complete and sign a health and medical history form provided by us;
2. submit to a medical examination, if requested;
3. provide any additional information and attending physicians' statements that we may require; and
4. furnish all such evidence at your own expense.

We will then determine if you are insurable under the plan.]

**WHEN COVERAGE STARTS**

**When does your coverage start?**

If you must contribute towards the plan's cost, your coverage will start on the date determined below:

1. the date you become eligible, if you enroll or have enrolled by then;
2. the date on which you enroll, if you do so within 31 days after the date you are eligible;
3. the date we approve your Evidence of Insurability, if you are required to submit Evidence of Insurability; or
4. the first day of the month following the Annual Enrollment Period if you enroll during an Annual Enrollment Period.

## **DEFERRED EFFECTIVE DATE**

### **Will coverage become effective if a disabling condition causes you to be absent from work on the date it is to start?**

If you are absent from work due to your:

1. accidental bodily injury;
2. sickness;
3. pregnancy;
4. Mental Illness; or
5. Substance Abuse,

on the date your insurance or increase in coverage would otherwise have become effective, the effective date of the coverage or increase in coverage will be deferred until you have been Actively at Work for one full work-day.

## **CHANGES IN COVERAGE**

### **[Can you change benefit options?**

You may change to an option providing increased or decreased benefits only:

1. during an Annual Enrollment Period; or
2. within 31 days of a Change in Family Status.

An increase in coverage will be subject to your submission of Evidence of Insurability that meets our approval.]

### **[When will a requested change in benefit options take effect?**

If you enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:

1. the first day of the month following the Annual Enrollment Period; or
2. the date we approve your Evidence of Insurability, if you are required to submit Evidence of Insurability.

If you enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the later of:

1. the date you enroll for the change; or
2. the date we approve your Evidence of Insurability if you are required to submit Evidence of Insurability.

Any such increase in coverage is subject to the limitations stated in the Deferred Effective Date provision]

### **Do coverage amounts change if there is a change in your class or your rate of pay?**

Your coverage may increase or decrease on the date there is a change in your class or Weekly Earnings. However, no increase in coverage will be effective unless on that date you:

1. are an Active Full-time Employee; and
2. are not absent from work due to your being Disabled.

If you were so absent from work, the effective date of such increase will be deferred until you are Actively at Work for one full day.

No change in your Weekly Earnings will become effective until the date we receive notice of the change.

### **What happens if the Employer changes the Plan?**

Any increase or decrease in coverage because of a change in the Schedule of Insurance will become effective on the date of the change, except that the limitations on increases stated in the Deferred Effective Date provision .

## **BENEFITS**

### **How do benefits become payable for Total Disability?**

If, while covered under this Benefit, you become Totally Disabled, and furnish proof to us that you remain Totally Disabled, we will pay the Weekly Benefit shown in the Schedule of Insurance.

The amount of any Weekly Benefit payable shall be reduced by the total amount of Other Income Benefits You receive as described in the Definitions section of this Policy. The amount of Your Weekly Benefit may also be reduced by certain benefits You could reasonably be expected to receive but for which You did not apply as described in the Definitions Section of the Policy. The Weekly Benefit will also be reduced by Your Current Weekly Earnings as described in the Partial Disability section of the Policy.

See the Schedule of Insurance for the Weekly Benefit [the Minimum Weekly Benefit,] the Maximum Duration of Benefits, and when Benefits Commence.

No benefits will be payable unless You are under the care of a Physician other than Yourself.

**Loss of License:** Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation alone, does not mean that You are Disabled. However, information relating to Your loss of license supporting Your claim for benefits may be submitted as part of Your proof of Loss.

## **PROOF OF LOSS**

### **How do benefits become payable for Total Disability?**

If, while covered under this Benefit, you become Totally Disabled, and furnish proof to us that you remain Totally Disabled, we will pay the Weekly Benefit shown in the Schedule of Insurance.

The amount of any Weekly Benefit payable shall be reduced by the total amount of all Other Income Benefits, including any amount for which you could collect but did not apply.

See the Schedule of Insurance for the Weekly Benefit, the Minimum Weekly Benefit, the Maximum Duration of Benefits, and when Benefits Commence.

No benefits will be payable unless you are under the care of a Physician other than yourself.

## **PARTIAL DISABILITY BENEFITS**

### **How are benefits paid for Partial Disability?**

If while covered under this benefit, You become Disabled and work on a part-time or limited duty basis because You are Partially Disabled, for the first 12 months of a return to work, We will reduce Your Weekly Benefit by Current Weekly Earnings only to the extent that such earnings when added to the Weekly Benefit payable exceed 100% of Your weekly Pre-disability Earnings.

### **How are benefits calculated after twelve months of benefits have been paid?**

After the first 12 month period of any Partial Disability and for any remaining or additional periods of Partial Disability, Your Weekly Benefit will be calculated as follows:

- 1) Multiply Your Indexed Pre-disability Earnings by the Benefit Percentage;
- 2) Compare the result with the Maximum Benefit; and
- 3) From the lesser amount, deduct Other Income Benefits and 50% of Your Current Weekly Earnings.

The result is Your Weekly Benefit.

[Your Weekly Benefit, however, will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.]

**How is a benefit calculated for a period of less than a week?**

If a Weekly Benefit is payable for less than a week, we will pay [1/5] of the Weekly Benefit for each day you were Disabled.

**When will benefit payments cease?**

Benefit payments will stop on the first to occur of:

1. the date you are no longer Disabled;
2. the date you fail to furnish proof that you continue to be Disabled;
3. the date you refuse to be examined, if we require an examination;
4. the last day benefits are payable according to the Maximum Duration of Benefits shown in the Schedule of Insurance; or
5. the date you die.

**RECURRENT DISABILITY**

**What happens to your benefits if you return to work as an Active Full-time Employee and then become Disabled again?**

If you return to work as an Active Full-time Employee for [ 30] consecutive days or more, any recurrence of a disability will be treated as a new Disability with respect to when Benefits Commence and the Maximum Duration of Benefits, as shown in the Schedule of Insurance.

If recurrent periods of Disability are:

1. due to the same or a related cause; and
2. separated by less than [ 30] consecutive days of work as an Active Full-time Employee,

they will be considered to be the same period of Disability.

**MULTIPLE CAUSES**

**How long will benefits be paid if a period of Disability is extended by another cause?**

If a period of Disability is extended by a new cause while weekly benefits are payable, weekly benefits will continue while you remain Disabled, subject to the following:

1. weekly benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2. the Exclusions and the Pre-existing Conditions Limitation will apply to the new cause of Disability.

**VOCATIONAL REHABILITATION**

**What is Vocational Rehabilitation?** Vocational Rehabilitation means employment or services that prepare You, if Disabled, to resume gainful work.

Our Vocational Rehabilitative Services include, when appropriate, any necessary and feasible:

1. vocational testing;
2. vocational training;
3. work-place modification;
4. prosthesis; or
5. job placement.

## REHABILITATIVE EMPLOYMENT

**Rehabilitative Employment** means employment that is part of a program of Vocational Rehabilitation.

### **Do earnings from Rehabilitative Employment affect the Weekly Benefit?**

If You are Disabled and are engaged in an approved program of Rehabilitative Employment, for the first 12 months that benefits are payable under this provision We will reduce Your Weekly Benefit by Your Current Weekly Earnings only to the extent that such earnings when added to the Weekly Benefit payable exceed 100% of Your weekly Pre-disability Earnings.

After 12 months of benefits have been paid under this provision and for any additional period of Rehabilitative Employment Your Weekly Benefit will be:

1. the amount calculated for Total Disability; but
2. reduced by 50% of the income received from each week of such Rehabilitative Employment.

The sum of Your Weekly Benefit and total income received under this provision may not exceed 100% of Your weekly Indexed Pre-disability Earnings. If this sum exceeds Your weekly Indexed Pre-disability Earnings, the Weekly Benefit paid by us will be reduced proportionately.

## PRE-EXISTING CONDITIONS LIMITATIONS

### **Are benefits limited for a Pre-existing Condition?**

This policy will not provide coverage for any period of Disability beginning within the first [12] months of the effective date of Your coverage under this policy if the period of Disability is caused by or substantially contributed to by a Pre-existing condition or the medical or surgical treatment of a Pre-existing condition.

You have a Pre-existing condition if:

1. You received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the [3] months immediately prior to the effective date of coverage under this Policy; or
2. You suffered from a physical or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in Your application and
  - a. for which You received a physician's advise or treatment within [ 3] months before the date of Your coverage under this policy; or
  - b. which caused symptoms within [3] months before the date of issue for which a prudent person would usually seek medical advice or treatment.

### **Is there continuity of coverage from a Prior Plan?**

If you become insured under the Group Insurance Plan on the Plan Effective Date and were covered under the Prior Plan on the day before the Plan Effective Date, the Pre-existing Conditions Limitation will cease to apply on the first to occur of the following dates:

1. the Plan Effective Date, if your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Plan; or
2. if your coverage was limited by a pre-existing condition restriction under the Prior Plan, the date the restriction would have ceased to apply had the Prior Plan remained in force.

## EXCLUSIONS

### **What Disabilities are not covered?**

The plan does not cover, and no benefit shall be paid for, any:

1. injury, sickness, Mental Illness, Substance Abuse, or pregnancy not being treated by a Physician or surgeon;
2. Disability caused or contributed to by war or act of war (declared or not);
3. Disability caused by Your commission of or attempt to commit a felony, or to which a contributing cause was Your being engaged in an illegal occupation;

4. Disability caused or contributed to by an intentionally self-inflicted injury;
5. [sickness or injury for which temporary Workers' Compensation benefits are paid; or]
6. [injury sustained as a result of doing any work for pay or profit for another employer.]

## **TERMINATION**

### **When does Your insurance terminate?**

Your insurance will terminate on the earliest of:

1. the date the Group Insurance Policy terminates;
2. the date the Group Insurance Policy no longer insures Your class;
3. the date premium payment is due but not paid by the Employer;
4. the last day of the period for which You make any required premium contribution, if You fail to make any further required contribution;
5. the date on which You cease to be an Active Full-time Employee in an eligible class, including:
  - a) temporary layoff;
  - b) leave of absence; or
  - c) work stoppage (including a strike or lockout); or
  - d) the date Your Employer ceases to be a Participant Employer, if applicable.

### **May coverage be continued during a family or medical leave?**

If You are granted a leave of absence according to the Family and Medical Leave Act of 1993, Your Employer may continue Your insurance for up to 12 weeks, or longer if required by state law, following the date Your coverage would have terminated, subject to the following:

1. the leave authorization must be in writing;
2. the required premium for You must be paid;
3. Your benefit level, or the amount of earnings upon which Your benefit may be based, will be that in effect on the day before said leave commenced; and
4. such continuation will cease immediately if one of the following events should occur:
  - a) the leave terminates prior to the agreed upon date;
  - b) the termination of the Group Insurance Policy;
  - c) non-payment of premium when due by the Policyholder or You;
  - d) the Group Insurance Policy no longer insures Your class; or
  - e) the date Your Employer ceases to be a Participant Employer, if applicable.

### **Does Your insurance continue while You are Disabled and no longer an Active Full-time Employee?**

If You are no longer an Active Full-time Employee because You are Disabled, Your Short Term Disability Insurance will be continued:

1. while You remain Disabled;
2. without payment of premium after the date we receive written notice of claim; and
3. until the end of the period for which You are entitled to receive Short Term Disability Benefits.

After Short Term Disability benefit payments have ceased, Your insurance will be reinstated, provided:

1. You return to work for one full day as an Active Full-time Employee in an eligible class;
2. the Group Insurance Policy remains in force; and
3. the required premium is paid.

### **Do benefits continue if the Group Insurance Policy terminates?**

If You are entitled to benefits while Disabled and the Group Insurance Policy terminates, benefits:

1. will continue as long as You remain Disabled by the same disabling condition; but
2. will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination for any reason of the Group Insurance Policy will have no affect on our liability under this provision.

## GENERAL PROVISIONS

### **Time limits on Certain Defenses: What happens if facts are misstated?**

After three years from the date of issue of this Policy, no misstatement of the employer, except a fraudulent misstatement made in the application shall be used to void the Policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any employee eligible for coverage under the Policy, except a fraudulent misstatement, made in an application under the Policy shall be used to deny a claim for loss incurred or disability (as defined in the Policy) commencing after expiration of such three years.

No claim for loss incurred or disability (as defined in the Policy) commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage with respect to which the claim is made.

### **Notice of Claim: When should We be notified of a claim?**

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to Us at our offices in Hartford, Connecticut, or to any of our authorized agents, with information sufficient to identify the insured, shall be deemed notice to the insurer.

### **Claim Forms: Are special forms required to file a claim?**

We will, upon receipt of written claim notice, furnish to You such forms as are usually furnished by us for filing proof of loss. If such forms are not furnished within 15 days after We receive written notice of claim You shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

### **Proof of Loss: When must proof of loss be given?**

Written proof of loss must be furnished to the insurer at our offices in Hartford, Connecticut in case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

### **Physical Examinations and Autopsy: What additional proof of Disability are We entitled to?**

At Our own expense, We shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

### **Payment of Claims: Who gets the benefit payments?**

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any indemnity of the policy shall be payable to Your estate or to a person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding \$1000.00 to any relative by blood or connection by marriage of such person or beneficiary whom We deem to be equitably entitled thereto. Any payment We make in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

### **Time Payment of Claims: When are payment checks issued?**

Indemnities payable under the policy for any loss other than loss for which the policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the policy provides periodic payment will be paid on a weekly basis and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

**What notification will You receive if Your claim is denied?**

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written decision will:

1. give the specific reason(s) for the denial;
2. make specific reference to the policy provisions on which the denial is based;
3. provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

**What recourse do You have if Your claim is denied?**

On any claim, the claimant or His representative must appeal to Us for a full and fair review.

1. You must request a review upon written application within:
  - a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
  - b) 60 days of receipt of claim denial for all other claims; and
2. You may request copies of all documents, records, and other information relevant to Your claim; and
3. You may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with our final decision on Your claim.

**Legal Action: When can legal action be started?**

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**How will We Determine Your Eligibility for Benefits?**

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits for any claim You make on The Policy. We will:

- 1) obtain, with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;
- 2) consider and interpret The Policy and all information obtained by Us and submitted by You that relates to Your claim for benefits and make Our determination Your eligibility for benefits based on that information and in accordance with the Policy and applicable law;
- 3) if We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
- 4) if We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with the Policy as described in the provision entitled "What notification will You receive if Your claim is denied?"

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled "What recourse do You have if Your claim is denied?" If You do not appeal the decision to Us, then the decision will be Hartford's final decision.

## DEFINITIONS

The terms listed will have these meanings:

**Active Full-time Employee** means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. Such employee must work the number of hours in the Employer's normal work week. This must be at least the number of hours for Full-time Employment shown in the Schedule of Insurance.

### **Actively at Work**

You will be considered to be actively at work with the Employer on a day which is one of the Employer's scheduled work days if you are performing, in the usual way, all of the regular duties of your job on a Full-time basis on that day. You will be deemed to be actively at work on a day which is not one of the Employer's scheduled work days only if you were actively at work on the preceding scheduled work day.

**Current Weekly Earnings** means the weekly earnings You receive from work You perform for Your Employer or for another employer with whom You became employed after Your Disability commenced.

**Employer** means the Policyholder.

**Mental Illness** means any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations or psychological, behavioral or emotional disorders, but excluding demonstrable structural brain damage.

**Other Income Benefits** mean the amount of any benefit for loss of income, provided to You as a result of the Disability for which You are claiming benefits under this plan. This includes any such benefits that are paid to You or to a third party on Your behalf. This includes the amount of any benefit for loss of income from:

1. the United States Social Security Act, Civil Service Retirement System, the Railroad Retirement Act, the Jones Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that You are eligible to receive because of Your Disability;
2. the Veteran's Administration or any other governmental agency for the same Disability;
3. any governmental law or program that provides disability benefits as a result of Your job with the Employer;
4. [[salary continuation],[ sick pay] or[ paid time off]];
5. the portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings;
6. any temporary disability benefits under a workers' compensation law, occupational disease law, or similar law.

[Other Income Benefits also means the amount of any benefit for loss of income, provided to Your family from the United States Social Security Act, The Railroad Retirement Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that Your family is eligible to receive as a result of the Disability for which You are claiming benefits under this plan. ]

You will not be required to claim any retirement benefits which You may only get on a reduced basis.

Any general increase in benefits required by law that You are entitled to receive under any Federal Law will not reduce the Short Term Disability Benefit payable for a period of Total Disability that began prior to the date of such increase.

If You are paid Other Income Benefits in a lump sum, We will pro-rate the lump sum:

1. over the period of time it would have been paid if not paid in a lump sum; or
2. if such period of time cannot be determined over a period of 26 weeks.

We may require:

1. Your signed statement identifying all Other Income Benefits; and
2. proof that You and Your family have duly applied for all Other Income Benefits We reasonably believe You[ or Your family] are entitled to or eligible to receive as a result of the Disability for which You are claiming benefits under this plan.

You will be required to apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You will be required to apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

- 1) to follow the process established by the Social Security Administration to reconsider the denial; and
- 2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals if such action can reasonably be expected to result in an award.

If You are eligible for benefits under The Canadian Pension Plan, The Quebec Pension Plan, Railroad Retirement Act, or other similar government plan You will be required to apply for such benefits if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits You are eligible to receive with reasonable diligence.

If Your disability was caused by a work injury, You will be required to apply for Workers' Compensation benefits with Your employer if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence.

If You are eligible for benefits from California State Disability Insurance or disability insurance from another state, You will be required to apply for California State Disability Insurance or disability insurance from another state if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence.

We will use any reasonable means to estimate the amount of Other Income Benefits payable under the Social Security Administration's Disability Income Program, the Canadian Pension Plan, The Quebec Pension Plan or any similar plan or act if We reasonably believe You [or Your family ] entitled or eligible to receive them but You [or Your family] have not applied; or failed to pursue them with reasonable diligence; or You have failed to provide Us with proof that You [or Your family] have applied for and reasonably pursued these benefits. We will deduct the estimated amount of this benefit from Your Weekly Benefit payable under this plan even if You [or Your family ] are not receiving these benefits.

We will use any reasonable means to estimate the amount of temporary disability benefits payable to You under a workers compensation law or any other occupational disease law or similar act; or the amount of benefits payable to You under any statutory benefit law, plan or act if We reasonably believe You are entitled or eligible to receive them but You have not applied; or failed to pursue them with reasonable diligence; or failed to provide Us with proof that You have applied for and reasonably pursued these benefits. We will deduct the estimated amount of these benefits from Your Weekly Benefit payable under this plan even if You are not receiving these benefits.

**Partial Disability or Partially Disabled** means that You are not Totally Disabled and, while actually working in an occupation, as a result of sickness or injury You are unable to engage with reasonable continuity in that or any other occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life and physical and mental capacity

**Physician** means a practitioner of a healing art, which we are required by law to recognize, who is properly licensed, and practicing within the scope of that license.

**Prior Plan** means the short term disability plan carried by the Employer on the day before the Plan Effective Date.

**Sickness vs. Accident**

A Disability shall be deemed to be caused by sickness, and not by accident, if:

1. it is caused or contributed to by:
  - a) any condition, disease or disorder of the body or mind;
  - b) any infection, except a pus-forming infection of an accidental cut or wound;
  - c) hernia of any type unless it is the immediate result of an accidental injury covered by this plan;
  - d) any disease of the heart;
  - e) Mental Illness;
  - f) Substance Abuse;
  - g) pregnancy;
  - h) any medical treatment for items (a) through (g) above; or
2. it is caused directly or indirectly by accident, but commences more than 30 days after the date of the accident.

**Substance Abuse** means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the substance; or
4. the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

**Substantial and Material Acts** means acts that are normally required for the performance of Your usual occupation and cannot be reasonable omitted or modified.

**Total Disability or Totally Disabled** means that as a result of sickness or injury You are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue Your usual occupation in the usual or customary way.

**We, us or our** means the Hartford Life and Accident Insurance Company.

**[Weekly Earnings** means your usual weekly rate of pay, [including/not including] [commissions] and [bonuses] received from the Employer, but not:

1. [overtime pay;] or
2. [any fringe benefit or extra compensation.]

[Bonuses will be averaged as follows:

1. over the most recent [12] month period prior to the date your disability began; or
2. over the number of calendar months you worked for the Employer prior to becoming Disabled, if you have worked for the Employer at least 6 months but less than 12 months; or
3. bonuses will not be included if you have worked for the Employer less than 6 months.]

[Commissions will be averaged as follows:

1. over the most recent [12] month period prior to the date your disability began; or
2. over the number of calendar months you worked for the Employer prior to becoming Disabled, if you have worked for the Employer at least 6 months but less than 12 months; or
3. commissions will not be included if you have worked for the Employer less than 6 months.]

If you become Disabled, your Weekly Earnings will be the rate in effect on your last day as an Active Full-time Employee before becoming Totally Disabled.]

**You or your** means the insured person to whom this Booklet-certificate is issued.

**ERISA INFORMATION**

**THE FOLLOWING NOTICE  
CONTAINS IMPORTANT INFORMATION**

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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**1. Plan Name**

Group Short Term Disability Plan for employees of ABC COMPANY.

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**2. Plan Number**

STD - 501

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**3. Employer/Plan Sponsor**

ABC COMPANY  
123 West Street  
Los Angeles, CA 90001

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**4. Employer Identification Number**

12-3456789

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**5. Type of Plan**

Welfare Benefit Plan providing Group Short Term Disability.

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**6. Plan Administrator**

ABC COMPANY  
123 West Street  
Los Angeles, CA 90001

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7. **Agent for Service of Legal Process**

For the Plan

ABC COMPANY  
123 West Street  
Los Angeles, CA 90001

For the Policy:

Hartford Life And Accident Insurance Company  
200 Hopmeadow St.  
Simsbury, CT 06089

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions** -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

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9. **Type of Administration** -- The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

None

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12. **Names and Addresses of Trustees**

None

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13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

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## STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

### 1. Receive Information About Your Plan and Benefits

- a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
- c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### 2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### 3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### 4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **CLAIM PROCEDURES**

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

### **Claim Procedures for Claims Requiring a Determination of Disability**

#### Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

#### Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

## **Claim Procedures for Claims Not Requiring a Determination of Disability**

### **Claims for Benefits**

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

## Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

**The Plan Described in this Booklet  
is Insured by the**

**Hartford Life and Accident Insurance Company**  
Hartford, Connecticut

**Member of The Hartford Insurance Group**