Employee: Gwendolyn Ulijasz
DOB: 05/27/78 **Underwriting ID:** 5901172-G
Enrolled through: COGNIZANT TECHNOLOGY SOLUTIONS U.S. CORPORATION

Applicant: Gwendolyn Ulijasz
All Coverage(s) Requested: Voluntary Life $900,000
Policy Number(s): 0GL715217

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March 12, 2024

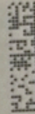
Gwendolyn Ulijasz
4223 Travis St
Dallas, TX 75205

Dear Gwendolyn,

We have received your request for re-evaluation of our decision to decline your request for group insurance coverage for yourself through COGNIZANT TECHNOLOGY SOLUTIONS U.S. CORPORATION.

When our file review has been completed, we will contact you with our decision.

If you have any general questions, please call our Customer Service Representatives at 1-800-331-7234. Our office hours are Monday through Friday, 8:00 AM to 6:00 PM Eastern Time. Or you may contact us at medical.uw@thehartford.com.



Sincerely,

Group Medical Underwriting Department

The Hartford
Group Medical Underwriting
P.O. Box 2999
Hartford, CT 06104-2999
Toll Free 800 331 7234

[Th]e Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance [Co]mpany and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT.

Applicant: Gwendolyn Ulijasz
Underwriting ID: 5901172-G
Policyholder: COGNIZANT TECHNOLOGY SOLUTIONS U.S. CORPORATION
Policy Number(s): 0GL715217

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HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza, Hartford, CT 06155

PSYCHOLOGICAL QUESTIONNAIRE

Based on your Personal Health Application (PHA), medical and/or prescription history, we require your treating Physician or Licensed Health/Mental Health Care Provider, complete this questionnaire for you to the best of their knowledge providing as much detail as possible. (Please note, we are unable to accept a questionnaire completed by yourself, a spouse or family member).

1. Please indicate all psychiatric/psychological diagnosis (es) (dx) and/or presenting condition(s) for treatment (tx)

Psychiatric/Psychological Dx	Date of Dx	Recurrent?		Indicate severity as mild/moderate/severe		
		☐ Yes	☐ No	☐ Mild	☐ Moderate	☐ Severe
		☐ Yes	☐ No	☐ Mild	☐ Moderate	☐ Severe
		☐ Yes	☐ No	☐ Mild	☐ Moderate	☐ Severe
		☐ Yes	☐ No	☐ Mild	☐ Moderate	☐ Severe

2. Are you the prescribing/treating provider for above condition(s)? ☐ Yes ☐ No Date of last visit: ________

3. Is there a history of substance abuse? ☐ Yes ☐ No Details: ________

____

4. Is there compliance with prescribed treatment regimen? ☐ Yes ☐ No Details: ________

____

5. Any history of suicidal ideation or attempt? ☐ Yes ☐ No If yes, dates/details: ________

____

____

6. Treatment Regimen:

A. Medication

Medication Prescribed	Dosage	Date Last Taken	Date Dose Changed with New Dose

B. Any history of insufficient or failed response to prior treatment? ☐ Yes ☐ No Details: ________

____

C. Psychotherapy: ________

D. Hospitalization (inpatient, partial hospitalization or ER)? Details: ______

E. Other Treatment ______

7. Is there any history of condition related work loss? ☐ Yes ☐ No Details: ______

8. Please provide most recent symptom-based psychological rating scale results if completed.

Tool	Date Administered	Score	Interpretation
PHQ-9			
Hamilton Depression Rating Scale (HAM-D)			
Beck			
Other ______			

9. If above rating scale not completed, please describe symptoms at last visit. ______

______

10. Any deficits in function or cognition? ☐ Yes ☐ No Details: ______

11. Any comorbid chronic illness such as chronic pain requiring narcotic pain medication, or diabetes? If yes, please provide condition(s) and treatment/medication regimen ______

12. Any additional information/details you wish to provide? ______

______

The above information submitted by physician or licensed health or mental health care provider below:

Printed Name ______ Signed ______ Date ______ Designation ______

Physician specialty ______

Address ______ Phone: ______

______

______

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