

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



March 12, 2024

000015 7/2

Gwendolyn Ulijasz
4223 Travis St
Dallas, TX 75205

Dear Gwendolyn,

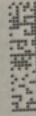
We have received your request for re-evaluation of our decision to decline your request for group insurance coverage for yourself through COGNIZANT TECHNOLOGY SOLUTIONS U.S. CORPORATION.

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



2500202000001163410100049*

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

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



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		
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> 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: _____

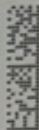
6. Treatment Regimen:

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: _____



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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: _____

* 2 0 0 0 2 0 1 0 0 0 0 0 0 1 1 6 3 4 1 0 3 0 1 8 1 8 *

Information in case pages get separated:

First Name Polyn	Middle Name	Last Name Ulijasz	Claim Number 110113037836
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SECTION 2: Information About Your Patient's Health (To be completed by the physician providing treatment for the disability condition.)

- Please provide all applicable information requested about your patient. The information you share will be used in making a decision about your patient's claim for disability benefits.
- After you complete this form, please submit it along with office notes and results from any diagnostic testing related to your patient's condition (e.g., x-ray, lab tests, EKG or MRI). See Section 4 below for instructions on how to submit this completed form and any supporting documents to MetLife Disability.

History Of Your Patient's Condition

First date of treatment for this condition (mm/dd/yyyy) _____ Most recent date of treatment (mm/dd/yyyy) _____

What is the cause of your patient's symptoms? (Check one)

- Injury
- Illness
- Pregnancy (Type of birth - Check one below)
 - Cesarean
 - Natural Birth
 - Not yet delivered: Expected delivery date (mm/dd/yyyy) _____

List any other physicians or specialists you referred your patient to:

First name	Last name	Specialty	Phone number

Is your patient's condition work-related? Yes No

Did you advise your patient to stop working? Yes On date (mm/dd/yyyy) _____ No

Has your patient been hospitalized for this condition? Yes On date (mm/dd/yyyy) _____ No

Facility Name _____

Address _____	City _____	State _____	ZIP _____
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About The Diagnosis And Treatment Of Your Patient

Primary Diagnosis Code _____	Description _____
Secondary Diagnosis Code _____	Description _____

First Name lyn	Middle Name	Last Name Ulijasz	Claim Number 110113037836
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Describe the symptoms your patient reported to you.

List your clinical findings and reports. *(Please include copies of results when you return this form to us)*

Describe the treatment plan you recommend for your patient.

If surgery has been performed or is anticipated, provide:

CPT-4 procedure code	Description	Date (mm/dd/yyyy)

List any medications prescribed:

Medication name	Dosage

About Your Patient's Restrictions and Limitations

Your patient's dominant hand *(Check One)*: Right Left

How many hours in a workday can your patient:

	Hours (0 to 8)	Continuously	Intermittently	Breaks Frequency	Duration
Sit	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stand	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Walk	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Climb	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Twist/Bend/Stoop	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Reach above shoulder level	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Reach front and side at desk level	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Perform fine finger movements	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Perform eye/hand movements	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

First Name: Polyn Middle Name: Last Name: Ulijasz Claim Number: 110113037836

How many hours in a workday can your patient lift or carry:

Weight	Hours (0 to 8)	Continuously	Intermittently	Breaks Frequency	Duration
Up to 10 lbs.	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
11 to 20 lbs.	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
21 to 50 lbs.	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
51 to 100 lbs.	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Over 100 lbs.	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

How many hours in a workday can your patient push or pull:

Weight	Hours (0 to 8)	Continuously	Intermittently	Breaks Frequency	Duration
Up to 10 lbs.	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
11 to 20 lbs.	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
21 to 50 lbs.	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
51 to 100 lbs.	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Over 100 lbs.	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Can your patient operate a motor vehicle? Yes No

Is your patient at maximum medical improvement? Yes No

Please make any additional notes.

About Your Patient's Prognosis

Have you advised your patient when they can return to work?

- Yes (Check all that apply)
 - To regular occupation. On date (mm/dd/yyyy) _____ Full-time Part-time Modified duty
 - To any other occupation. On date (mm/dd/yyyy) _____ Full-time Part-time Modified duty
- No (Please explain)

List any restrictions to work or activity. (Please be as specific as possible.)

Claims



Physician Statement

Use this form to provide us with the information we need from you and your physician to process your claim for disability benefits.

Metropolitan Life Insurance Company

Things to Know Before You Begin

- You should complete and sign Section 1 of this form before giving it to your physician. If the form is sent directly to your physician, you may have your physician complete Section 1 for you. Section 2 **MUST** be completed by your physician.
- Submitting an incomplete form may delay processing your claim.
- Some physicians may charge for completion of this form. Any such charge is your responsibility.
- 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.

! Please write the claim number on any additional documents you send.

SECTION 1: Claim Information (To be completed by the person submitting the claim, or by the physician if received directly.)

Claimant First Name Gwendolyn	Middle Name	Last Name Uljasz
Date of Birth (mm/dd/yyyy) 05/27/1978	Customer Name COGNIZANT TECHNOLOGY SOLUTIONS US CORPORATION	Occupation
Physician First Name Katherine	Last Name Spangenberg MD	
Physician Phone Number 708 327 1410	Claim Number 110113037836	

Authorization For Physician to Share My Medical Information

I authorize my physician to release to MetLife Disability any information collected in the course of examining or treating me as a patient.

Sign Here	Claimant Signature	Date (mm/dd/yyyy)

REQUIRED information in case pages get separated:

Claimant First Name Swendolyn	Middle Name	Last Name Ulijasz	Claim Number 110113037836
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If we need more information, who's the best person at your office to contact? (Please provide name and phone number/extension.)

SECTION 3: Physician's Signature and Information

First Name Katherine	Last Name Spangenberg		
Address 7005 W. North Ave	City Oak Park	State IL	ZIP 60302
Degree or Specialty Med Peds	Office Phone Number 708-327-1410	Office Fax Number 708-383-8932	Tax ID 36-4015560

Sign Here	Signature of Physician	Date (mm/dd/yyyy)

SECTION 4: How to Submit this Form

Please send all of the pages of this form and any supporting documents, adding the claim number to the top of each page, to MetLife Disability by:

Mall:
MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:
1-800-230-9531