GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Employee/Member/Claimant Statement

The Hartford - In furnishing this form, The Hartford® does not waive any of its rights or defenses nor admit liability.

THE HARTFORD

Employee/Member/Claimant Responsibilities:

1) Complete, sign and date this form. For assistance with completing this form, please call (866)547-4205.
2) To help prove the claim, provide all supporting documentation such as medical records, physician notes, ER/hospital discharge papers, radiology/pathology reports, itemized medical/hospital bills, medical EOBs, toxicology reports, child care/transportation/lodging receipts or police reports (if applicable following an accident). The claimant is responsible for any fees charged for proof requirements.
3) Submit the form and required documentation to The Hartford Supplemental Health Benefit Department, PO Box 99906, Grapevine, TX 76099; or fax to (469)417-1952.
4) If you are enrolled for any other group coverage through The Hartford for which benefits may be available as a result of the covered event, please submit the appropriate claim(s). Contact the employer/policyholder for assistance if you are uncertain of other coverage.

EMPLOYER/POLICYHOLDER INFORMATION

Employer/Policyholder Name	**Policy Number**

EMPLOYEE/MEMBER INFORMATION

Employee/Member Name (First MI Last)	**SSN or Tax ID #**	**Gender** ☐ Male ☐ Female
Address (Street, City, State & Zip)		**Date of Birth**
E-mail Address	**Phone Number**	**Cell/Mobile Number**
May we have your authorization to deliver confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No **Via email?** ☐ Yes ☐ No; If Yes to either personal cell phone or email, please initial here to confirm your response: _____		
Does the employee/member have major medical insurance or other primary health insurance? ☐ Yes* ☐ No	***If Yes, provide name of insurance carrier and policy number:**	
Is the employee/member currently actively working?* ☐ Yes ☐ No; *If No, provide date last worked and reason:*		**Hours Worked/Week***

*Complete these fields only if there is an employer/employee relationship between the employee/member and the group. Do not complete for other group types.

DEPENDENT INFORMATION – COMPLETE IF THIS CLAIM IS FOR A DEPENDENT OF THE EMPLOYEE/MEMBER

Dependent Name (First MI Last)	**SSN or Tax ID #**	**Date of Birth**	**Relationship** (To employee/member)
Is the dependent insured under Medicaid or any similar Title XIX program? ☐ Yes ☐ No	**Is the child incapacitated/ disabled?** (If applicable) ☐ Yes ☐ No	**Is the child married or in a partnership?** (If applicable) ☐ Yes ☐ No	
Is the child a full-time student? (If applicable) ☐ Yes* ☐ No	***If Yes, provide name and contact info for the school:**		

CLAIM INFORMATION

Type of Claim (Check all that apply) ☐ Accident ☐ Critical Illness/Specified Disease ☐ Hospital Indemnity	**Is this the first claim submitted for this event/insured?** ☐ First Claim ☐ Additional/Follow-Up Claim
Nature of Illness/Injury/Diagnosis and/or Treatment Received* (For pregnancy, complete Pregnancy Information section below)	
When did symptoms first appear or injury occur?* (For accidents, complete Accident Information section below)	**Date First Diagnosed/Treated**
Have you ever had this same or similar condition? ☐ No ☐ Yes; Explain what and when:*	

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/Tax ID# and policy #.

PREGNANCY INFORMATION – COMPLETE IF THIS CLAIM IS THE RESULT OF A PREGNANCY

Date of Delivery/Expected Delivery Date	**Type of Delivery/Expected Type of Delivery** ☐ Vaginal ☐ Elective C-section ☐ Unplanned C-section	**First Day of Last Period**
Are/were there any complications of pregnancy? ☐ No ☐ Yes; Explain what and when:*		

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/Tax ID# and policy #.

ACCIDENT INFORMATION – COMPLETE IF THIS CLAIM IS THE RESULT OF AN ACCIDENT

Date of Accident	**Time of Accident** (HH:MM) ☐ AM ☐ PM	**Who was involved in the accident?** (Check all that apply) ☐ Employee/Member ☐ Spouse ☐ Child(ren)
Location of Accident (Place Name, Street, City, State & Zip)		

Complete the rest of this section only if this claim is the first claim submitted for this injured person for this accident. Proceed to the Benefit Information section if this is an additional/follow-up claim.

Was this a motor vehicle accident? ☐ Yes ☐ No	**Did any law agency investigate the accident?** ☐ Yes* ☐ No; *If Yes, provide a copy of report.*	***If Yes, provide agency name and contact info:**
Did the accident happen while the injured person was working? ☐ Yes** ☐ No		****If Yes, will/has a worker's comp (or equivalent) claim been filed?** ☐ Yes/To be Filed ☐ No

Provide a detailed explanation of the accident, including how it happened and what the injured person was doing at the time of the accident:***

*****If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/Tax ID# and policy #.

BENEFIT INFORMATION

Check each illness, injury, service or treatment for which a benefit is requested as a result of the event. If any previous claims have been submitted for this event, only check the benefits that are applicable to this new claim.

Benefits listed below may not be included in all certificates/policies. Refer to the certificate for available benefits, limitations and exclusions.

All relevant supporting documentation, such as medical records, physician notes, ER/hospital discharge papers, radiology/pathology reports, itemized medical bills (hospital, physician, ambulance, etc.), medical EOBs, toxicology reports or child care/ transportation/lodging receipts, should be included with this claim submission to help prove the claim. You can prevent the potential of a delay in processing the claim by providing complete and accurate information.

ACCIDENT

Emergency, Hospital & Treatment Care
- ☐ Physician Visit
- ☐ Urgent Care Visit
- ☐ Emergency Room
- ☐ Diagnostic Exam or X-Ray
- ☐ Ambulance
- ☐ Hospital Confinement
- ☐ Physical or Occupational Therapy
- ☐ Chiropractic Care or Acupuncture
- ☐ Rehabilitation Facility Confinement
- ☐ Transportation or Lodging
- ☐ Blood/Plasma/Platelets
- ☐ Emergency Dental – Crown/Extraction
- ☐ Accidental Ingestion of Controlled Drug
- ☐ Medical Appliance
- ☐ Child Care

Specified Injury & Surgery
- ☐ Concussion or Laceration
- ☐ Dislocation or Fracture
- ☐ Surgery
- ☐ Burns (Second or Third Degree)
- ☐ Eye Injury – Surgery or Object Removal
- ☐ Hernia Repair
- ☐ Joint Replacement

Catastrophic
- ☐ Death (Complete Death claim form)
- ☐ Coma
- ☐ Dismemberment or Paralysis
- ☐ Home Health Care
- ☐ Prosthesis

Other (Must be included in certificate/policy)
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

HOSPITAL INDEMNITY

Confinement
- ☐ Hospital Confinement
- ☐ Continuous Care Confinement

Family Care
- ☐ Travel or Lodging
- ☐ Family Care
- ☐ Pet Care

Additional Care
- ☐ Ambulance
- ☐ Emergency Room
- ☐ Hospital Observation/Short Stay
- ☐ Diagnostic Exam, Lab Test or X-Ray
- ☐ Durable Medical Equipment
- ☐ Prescription Drug

Medical Professional Care
- ☐ Medical Professional/Physician Visit
- ☐ Urgent Care Visit
- ☐ Telemedicine Visit
- ☐ Therapy Services
- ☐ Home Health Services
- ☐ Durable Medical Equipment
- ☐ Prescription Drug

Other
- ☐ Inpatient Surgery
- ☐ Outpatient Surgery
- ☐ _____
- ☐ _____
- ☐ _____

Riders
- ☐ AD&D (Complete Accident Catastrophic section to the left)
- ☐ Term Life (Complete Death claim form)
- ☐ Critical Illness (Complete Critical Illness section to the left)
- ☐ Short Term Care

CRITICAL ILLNESS/SPECIFIED DISEASE

Cancer
- ☐ Cancer (Invasive or Non-Invasive)
- ☐ Benign Brain Tumor
- ☐ Skin Cancer
- ☐ Second Opinion
- ☐ Prosthesis/Wig

Vascular
- ☐ Heart Attack (Myocardial Infarction)
- ☐ Stroke
- ☐ Coronary Artery Disease/Bypass
- ☐ Heart Transplant
- ☐ Aneurysm or Angioplasty/Stent

Other Illnesses
- ☐ Major Organ Transplant
- ☐ End Stage Renal (Kidney) Disease
- ☐ Coma or Paralysis
- ☐ Loss of Hearing, Speech or Vision
- ☐ Bone Marrow Transplant
- ☐ Occupational HIV/Hep

Neurological
- ☐ Advanced Parkinson's or Alzheimer's
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Advanced Multiple Sclerosis

Child
- ☐ Cerebral Palsy
- ☐ Congenital Heart Disease
- ☐ Cystic Fibrosis
- ☐ Muscular Dystrophy
- ☐ Spina Bifida

Other (Must be included in certificate/policy)
- ☐ Transportation or Lodging
- ☐ Physical Therapy or Home Health Care
- ☐ Rehabilitation Facility Confinement
- ☐ _____
- ☐ _____

FORM CONTINUES ON NEXT PAGE

PHYSICIAN INFORMATION* – INCLUDE ALL PHYSICIANS CONSULTED FOR CARE FOR THIS EVENT*

1/Physician Name		**2/Physician Name**		**3/Physician Name**	
Date(s) Treated	**Specialty**	**Date(s) Treated**	**Specialty**	**Date(s) Treated**	**Specialty**
Address (City, State & Zip)		**Address** (City, State & Zip)		**Address** (City, State & Zip)	
Phone #	**Fax #**	**Phone #**	**Fax #**	**Phone #**	**Fax #**

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/TAX ID# and policy number.

FACILITY INFORMATION – INCLUDE ANY URGENT CARE, ER OR HOSPITAL PROVIDING CARE FOR THIS EVENT*

1/Facility Name		**2/Facility Name**		**3/Facility Name**	
Date & Time Seen/Admitted ☐ AM ☐ PM		**Date & Time Seen/Admitted** ☐ AM ☐ PM		**Date & Time Seen/Admitted** ☐ AM ☐ PM	
Date & Time Discharged (If applicable) ☐ AM ☐ PM		**Date & Time Discharged** (If applicable) ☐ AM ☐ PM		**Date & Time Discharged** (If applicable) ☐ AM ☐ PM	
Address (City, State & Zip)		**Address** (City, State & Zip)		**Address** (City, State & Zip)	
Phone #	**Fax #**	**Phone #**	**Fax #**	**Phone #**	**Fax #**

*If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, SSN/TAX ID# and policy number.

CLAIMANT INFORMATION – COMPLETE ONLY IF THE CLAIMANT **IS NOT** THE EMPLOYEE/MEMBER

Claimant Name (First MI Last)	**Phone Number**	**Cell/Mobile Number**
Complete Mailing Address (Street/Box, City, State & Zip)	**E-mail Address**	
May we have your authorization to deliver confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No **Via email?** ☐ Yes ☐ No; If Yes to either personal cell phone or email, please initial here to confirm your response: _____		

CLAIMANT CERTIFICATION

By signing below, I hereby certify that:
1) The information provided on this form is true and complete to the best of my knowledge and belief; and
2) I have read and understand the "Important Notice–Fraud Warning Statements" that applies to my state of residence.

Claimant Signature	**Date of Signature**

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Emplyee/Member/Claimant Responsibilities:

1) A copy of this form must be submitted for each person for whom benefits are being claimed. This form is only required once per person per event, regardless of the number of claim submissions. For assistance, please call (866)547-4205.
2) Submit the form(s) to The Hartford Supplemental Health Benefit Department, PO Box 99906, Grapevine, TX 76099; or fax to (469)417-1952.

EMPLOYEE/MEMBER & POLICY INFORMATION

Employee/Member Name (First MI Last)	**Last 4 Digits of SSN or Tax ID #**	**Policy Number**

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local, and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford and its representatives, the following personal, private, or privileged information, records, or documents related to:

Insured's Name (Please Print) _____ Date of Birth _____ Employer/Policyholder's Name: _____

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or substance abuse, and behavioral or mental health (but excluding psychotherapy notes); work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security or other government benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and /or leave request(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as “My Information.”

I understand that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. Without limiting the foregoing, I authorize The Hartford to use or disclose My Information (i) to my employer for: a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, grievance, alternative dispute resolution, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer’s benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance, reinsurance or analytical purposes, including workers’ compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes ; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud. I understand that My Information disclosed to The Hartford and re-disclosed to others could include information regarding alcohol and substance abuse, HIV/AIDS, other communicable diseases, and behavioral and mental health records.

(Continue to next page)

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my written revocation, if earlier, except as may be reasonably necessary to prevent or detect perpetration of a fraud, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself. I understand that if The Hartford is the administrator of my employer's self-insured disability program or leave program that my employer is entitled to receive my records without this Authorization. I understand that a revocation of this Authorization is not effective to the extent that any of my Record Holders or The Hartford has relied on this Authorization or to the extent that the Hartford has a legal right to contest a claim for benefits or to contest the policy. If I do not sign this Authorization, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in a delay or denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

NOTICE TO INFORMATION PROVIDERS:
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

_____ _____

Signature of Claimant or Legal Representative **Date**

_____

Name and Relationship to Claimant ***(if signed by Legal Representative)***

Form must be signed and dated.

GROUP ACCIDENT, CRITICAL ILLNESS/SPECIFIED DISEASE & HOSPITAL INDEMNITY CLAIM FORM

Important Notice - Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For Residents of California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of Ohio: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

For residents of 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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____