Group (Stand Alone) Accidental Death & Dismemberment Claim Forms for Employee or Dependent

THE HARTFORD

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Employer and Employee/Beneficiary, as applicable.

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms. Also, please read the "Important Notice" on page 3.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Basic, Supplemental and Dependent AD&D coverage.

Part I - Employer's Statement

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Employer/Plan. If this is a death claim, a certified Death Certificate stating cause and manner of death must be attached to this form.
- ☐ Proof of salary as defined in the Policy (attach W2 or commissions, if applicable)
- ☐ Submission of claims on any voluntary or contributory AD&D plans, including Dependent coverage, must include copies of the enrollment forms and history.
- ☐ All claims must be submitted, along with the beneficiary designation forms then on file with the Employer/Plan, if any. If none on file, the Employer/Plan shall certify to that fact on the claim form.

Part II - Beneficiary Statement

- ☐ If more than one beneficiary, each beneficiary can either sign and date one form, or each can complete separate forms, showing their current address(es), date(s) of birth and Social Security Number(s).
- ☐ Your signature on the Medical Release of Information Authorization.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Basic, Supplemental and Dependent AD&D coverage.

Part III - Claimant's Statement.

- ☐ Must be completed by claimant or beneficiary alleging any death or dismemberment is due to an accident.
- ☐ Additionally, please furnish any newspaper accounts, police or motor vehicle reports, autopsy/toxicology or other pertinent information regarding the claim for accidental death or injury.

Part IV - Attending Physician's Statement (needed for Dismemberment/Sight/Hearing/Speech claims ONLY)

- ☐ Attending Physician should complete pages 6 and 7 for above losses.

Miscellaneous - All Claims

- ☐ If the claim proceeds are payable to an Estate, Executors or Administrators of the Estate, Part II and/or III must be completed by an Executor or Administrator. An official certificate of such person's legal appointment and qualification must be attached to this form. Please include the Estate Tax Identification Number. If none available, please explain.
- ☐ If any designated beneficiary is a minor, Part II and/or III must be completed by a custodian or guardian. An official certificate of the guardian's legal appointment and qualification of the minor's estate or property must be attached to this form, if applicable.
- ☐ If claim is for a dependent child enrolled in an accredited school of higher learning, submitted documents should include a student enrollment verification form executed by the school.
- ☐ Foreign Death -- Include both the Official Death Certificate and the Death of American Citizen Abroad form.

Release of claim forms is not an admission of coverage under a policy for an employer, group or organization.

Clear Form

Mail to: The Hartford
Group AD&D Claims Unit
P. O. Box 14299
Lexington, KY 40512-4299
1-888-563-1124

THE HARTFORD

PART I - Employer's Statement
Accidental Death & Dismemberment Claim Form for EMPLOYEE or DEPENDENT
(Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly)

Group Policy Holder/Employer Name:

Name of Insured Employee/Participant:	Date of Birth:	Social Security Number:
Name of deceased or Injured (if different from above)	Date of Birth:	Social Security Number
Address	Occupation of Deceased/Injured:	

Relationship to Employee: ☐ Spouse ☐ Child	Age:	Telephone Number:	Employee Class #:	Location:

Is a Beneficiary Designation Card on file? ☐ Yes ☐ No If "Yes," a copy must be submitted.

Employee's Annual Salary as defined in policy:
$ _____
(Attach W-2, if applicable)

☐ Hourly ☐ Weekly
☐ Monthly ☐ Annually

Does this amount include overtime, commissions or bonuses? ☐ Yes ☐ No

Effective Date of above Reported Salary: _____
(Month, Day, Year)

Date employee last physically reported to work: _____
(Month, Day, Year)

Amount of **Employee's** coverage being claimed:
Basic AD&D $ _____

Suppl/Voluntary AD&D $ _____

Are amounts indicated above reduced due to age reductions on the policy? ☐ Yes ☐ No.
Note: Changes in amounts of coverage, or increases in coverage, may not apply if the employee was absent from work due to illness or injury on the effective date of the change or increase. Changes or increases are deferred until the employee returns to active full-time work.

Is Employee Actively at Work?
☐ Yes ☐ No If "No," reason

☐ FMLA (provide approval form)

Amount of **Dependent's** coverage being claimed:
Basic AD&D $ _____

Suppl/Voluntary AD&D $ _____

Are amounts indicated above reduced due to age reductions on the policy? ☐ Yes ☐ No.

Is Dependent insurance in force?
☐ Yes ☐ No

Effective Date: _____
(Month, Day, Year)

Was Dependent over age 19?
☐ Yes ☐ No

Was Dependent a full-time student?
☐ Yes ☐ No

Date of death or injury: _____
(Month, Day, Year)

Group Policy Numbers:
AD&D: _____
Voluntary AD&D: _____

Employee's full-time Employment:
From: _____
(Month, Day, Year)
To: _____
(Month, Day, Year)

Date of Retirement : _____
(Month, Day, Year)

Date of Termination _____
(Month, Day, Year)

Reason employee did not return to work:

Was claim for Long Term Disability or Waiver of Premium ever approved? ☐ Yes ☐ No

Has this employee converted this Group policy to an Individual policy? ☐ Yes ☐ No

Are there absolute assignments on file?
☐ Yes ☐ No If "Yes" explain.

Employer Certification: *I hereby certify that the information provided on the Employer Statement is true and complete according to the records of the Employer. I agree that this information is subject to audit by Hartford Life Insurance Company or Hartford Life and Accident Insurance Company and/or its representative.*

Dated: _____ Address: _____

_____ By: _____
(Employer) (Their Authorized Representative) [Please print].

_____ _____
(e-mail address) : (Signature)

( ) _____ ( ) _____
Telephone Number: Facsimile Number

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 California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, 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 California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent 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, Virginia 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 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.

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 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.

Signature _____ Date _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To: Any health care provider, employer, benefit plan, insurer, service provider, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to The Hartford[1] a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

Insured's Name (*Please print*)	Date of Birth	Last 4 Digits of Social Security Number

Any and all medical information or records, including x-ray films, medical histories, physical, mental, or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits and bank records; business transactions billing, invoice, and payment records; academic transcripts; and information concerning Social Security 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 for the purpose of evaluating and administering my claim for benefits and/or leave request. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

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. I authorize The Hartford to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to complaints by me or my representative relating to benefits or leave; d) responding to any litigation or agency document production request or lawful subpoena; e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers of my employer's benefit plan, other benefits, and/or leave programs of my employer for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan 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 or reinsurance purposes, including workers' compensation insurance; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; or (ix) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make, unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured, Beneficiary or Personal Representative	Date	Relationship to Insured (*if not signed by Insured*)

[1] The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company.

Group Life and/or Accidental Death Claim Form for EMPLOYEE or DEPENDENT

THE HARTFORD

PART II - Beneficiary's Statement

Name of Deceased: ______________________ **Policy Number(s):** ______________

Claim Number (if known): ____________

Under penalties of perjury, I certify that:

(1) the number shown on this form is my correct taxpayer identification; and

(2) I am not subject to a back-up withholding, because, (a) I am exempt from back-up withholding; or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends; or (c) the IRS has notified me that I am no longer subject to back-up withholding; and

(3) I am a U.S. person (including a U.S. resident alien).

Certification Instructions: You must cross out item (2) above, if you have been notified by the IRS that you are currently subject to back-up withholding, because, you have failed to report all interest and dividends on your tax return.

By signing below:

(1) **I Hereby Certify and Agree** that I have read and understand the IMPORTANT NOTICE on page 3 of this claim form package.

(2) **I understand and Agree** that payment of the claim proceeds according to any alternate mode of settlement specified in the policy will only be made if the Company receives a written request for such alternate method of payment from me prior to the payment of the claim proceeds.

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	Telephone Number: Day: ( ) Evening: ( )	
Personal Cell Telephone Number: ( ) ________ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail: ☐ Yes ☐ No Please initial: ________ to confirm your election		
The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.		
Signature: **X**	Date:	E-mail address:

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	Telephone Number: Day: ( ) Evening: ( )	
Personal Cell Telephone Number: ( ) ________ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail: ☐ Yes ☐ No Please initial: ________ to confirm your election		
The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.		
Signature: **X**	Date:	E-mail address:

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	Telephone Number: Day: ( ) Evening: ( )	
Personal Cell Telephone Number: ( ) ________ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail: ☐ Yes ☐ No Please initial: ________ to confirm your election		
The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.		
Signature: **X**	Date:	E-mail address:

Mail to: The Hartford
Group AD&D Claims Unit
P. O. Box 14299
Lexington, KY 40512-4299

1-888-563-1124

THE HARTFORD

PART III - Claimant's Statement of Accidental Death or Injury

INSTRUCTIONS: Complete this form if you are applying for death or dismemberment benefits due to an Accident. If a question does not apply, please mark "N/A."

GROUP POLICYHOLDER/EMPLOYER NAME: _____

Name of Insured Employee/Participant	**Social Security Number**	**Policy Number(s)** AD&D _____ _____

Name of Deceased or Injured (if different from above)

Relationship to Employee: ☐ Spouse ☐ Child Age:

Has a Workers' Compensation claim been filed? ☐ Yes ☐ No
If "Yes," what is the status of the claim?

On what date did the accident happen? _____ Where did the accident happen? City _____ State _____
Please describe all injuries received.

Did accident result in death? ☐ Yes ☐ No If "Yes," on what date? _____

Describe in detail how the accident happened

Name and address of law enforcement agency involved (Please submit copy of Police Accident Report and/or provide Case Number).

List name/address/phone number of all physicians consulted for this injury/death.

List name/address/phone number of all hospitals consulted.

Did the deceased/injured have any chronic disease or physical defect or deformity? ☐ Yes ☐ No If "Yes," describe in detail:

Was autopsy performed? ☐ Yes ☐ No If "Yes," provide name/address/ telephone number of coroner, if known.

Was an inquest held? ☐ Yes ☐ No
If "Yes,' verdict?

Name of Beneficiary	Address	Telephone Number ( )	Date

Your date of birth _____ In what capacity are you making claim? _____
(Note: if other than beneficiary, attach appropriate legal documents substantiating your authority.)

Your address _____ and

Telephone number ( ) _____ (if different from beneficiary).

Your relationship to deceased or injured _____ Your Social Security Number _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates, or information concerning the deceased or injured's occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, HIV, and alcohol/drug records to release all such records in their entirety to Hartford Fire Insurance Company, Hartford Life and Accident Insurance Company, Hartford Life Insurance Company and any affiliate of any one or more of these companies (collectively and severally, the "Company"). I understand that I may receive a copy of this authorization, and that this authorization is valid for the entire duration of this claim, and that I may revoke this authorization at any time by sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to the employer, regulatory state agency, or Workers' Compensation carrier.

SIGNATURE OF PERSON COMPLETING THIS FORM	DATE

DISMEMBERMENT FILING ONLY

PART IV - Attending Physician's Statement
Dismemberment - Loss of Sight/Hearing/Speech

THE HARTFORD

Please print - Use a separate sheet of paper, if necessary

Patient's Name	Date of Birth	Social Security Number

Address (Street, City, State & Zip Code)

On what date did you first examine and treat the patient for this injury?_____ Where? _____

Had patient previously had medical attention for this injury? ☐ Yes ☐ No If "Yes," by whom?

Describe the injury and its affected body part(s).	Date of injury

What complications, if any, have arisen?

What surgery was performed?	Date of surgery

Name of Surgeon

Name and address of Hospital

From: _____

To: _____

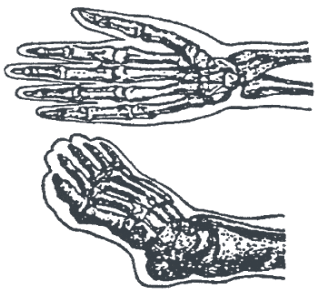
Was the injury described above, of itself, and independent of all other causes, sufficient to require amputation? ☐ Yes ☐ No

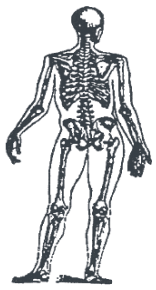
Was the injury described solely responsible for the loss? ☐ Yes ☐ No

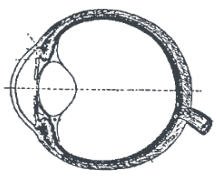
If "No," give the particulars of any contributing cause or causes?

Was claimant under the influence of alcohol and/or other drugs at the time of the accident or injury? ☐ Yes ☐ No ☐ Unknown

Please indicate location of amputation or area of injury, adding any necessary comments on chart provided.







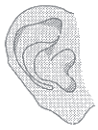
Please indicate best corrected visual acuity and/or area of injury as of _____ (Date).

Right eye:	_____	Corrected	_____	Uncorrected
Left eye:	_____	Corrected	_____	Uncorrected

Is this loss of sight (due to injury) irrecoverable?
☐ Yes ☐ No

DISMEMBERMENT FILING ONLY

PART IV - Attending Physician's Statement
Dismemberment - Loss of Sight/Hearing/Speech [Page two]



In your medical opinion, has this patient sustained complete and irrecoverable hearing loss due to an injury?

☐ Yes ☐ No ☐ Right ☐ Left ☐ Both

Please provide copies of auditory test results.

In your medical opinion, has this patient sustained complete and irrecoverable loss of speech due to an injury?

☐ Yes ☐ No

Please provide copies of speech test results.

Physician Name: (please print)

Street Address:	City/Town:	State/Province:	Zip Code:

Faxsimile number:	Telephone number:	Taxpayer's Identification Number:
( )	( )	

Physician's Signature:	Specialty/Degree:	Date:

Please return completed form(s) to:

The Hartford
Group AD&D Claims Unit
P. O. Box 14299
Lexington, KY 40512-4299
1-888-563-1124