

Accidental Dismemberment Claim Forms for Employee or Dependent



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 4.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Basic, Supplemental and Dependent Dismemberment benefits.

Part I - Employer's Statement

- Form is to be completed in its entirety and signed by the Official Representative of the Employer/Plan.
- Proof of salary as defined in the Policy (attach W2 or commissions, if applicable)
- Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of the enrollment forms and history to show timely enrollment.

The Company reserves the right to require or to obtain further proof of information if deemed necessary

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Basic, Supplemental and Dependent Dismemberment benefits.

Part II - Claimant's Statement

- Must be completed by claimant or insured claiming any dismemberment due to an accident.
- Additionally, please furnish any police or motor vehicle reports, toxicology or other pertinent information regarding the claim for accidental dismemberment or injury.
- Your signature on the Authorization to Obtain and Release Information Form (page 3).

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

- Attending Physician should complete pages 5 and 6 for above losses.

Miscellaneous - All Claims

- 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.

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



PROOF OF DEATH FORM (Group Life Insurance)
EMPLOYEE or DEPENDENT

PART I - EMPLOYER'S STATEMENT - TO BE COMPLETED IN FULL FOR ALL CLAIMS

Group Policy Numbers:		Employer:	
Life/ AD&D: _____ Voluntary AD&D: _____ Group Travel: _____			
Name of Insured /Participant:		Social Security Number:	
Insured's address: (Street, City, State & Zip Code)		Date of Birth:	
Branch/Location:	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Date of Hire:	Effective date of employee's insurance: _____ Premiums paid to date? <input type="checkbox"/> Yes <input type="checkbox"/> No
Occupation:	Classification	Provide employee's actual date last physically at work: _____	
Provide reason employee did not return to work on their next scheduled workday: <input type="checkbox"/> Illness <input type="checkbox"/> FMLA (provide approval form) <input type="checkbox"/> Retirement - Date: _____ <input type="checkbox"/> Other (please explain): _____			

AMOUNT OF INSURANCE BEING CLAIMED FOR EMPLOYEE OR AMOUNT IN FORCE FOR EMPLOYEE IF DEPENDENT CLAIM

Basic AD&D in force: \$ _____	Supplemental AD&D in force: \$ _____	(Employee's earning as defined in the policy. Attach W-2 if applicable) Rate of earnings used to calculate benefit amount: _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
Dismemberment/Loss of Sight Amount Being Claimed List Total Dismemberment Amount Being Claimed \$ _____		Regular hours scheduled to work: (if applicable) _____
Coverage claimed above, reflect age reduction(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Effective date of above reported earnings: _____
Date insurance was discontinued or not in force _____		Do the earnings include commissions or bonuses? <input type="checkbox"/> Yes <input type="checkbox"/> No
Indicate if any of the following apply to this Employee: <input type="checkbox"/> Applied for Conversion <input type="checkbox"/> Has been approved for LBO/Accelerated Death Benefits by prior carrier <input type="checkbox"/> Has been approved for Long Term Disability <input type="checkbox"/> Has been approved for Waiver of Premium by prior carrier		
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. Changes in amounts of coverage and increases are deferred until employee returns to active full-time work. If the employee elected increases in coverage during the past two years, the amount being claimed reflects the increase, attach copies of the election forms.		
State name and amounts of other insurance policy(ies), if any.		

DEPENDENT INFORMATION - ONLY COMPLETE FOR DEPENDENT CLAIM

Full Name of Deceased Dependent	Deceased's Social Security Number	Date of Birth	Relationship to Employee
Last Residence: (Number, Street, City or Town, Zip Code)	Is Employee Actively at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete date last worked and reason above	Have premiums been paid to date for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the dependent child, over the Policy's limiting age? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the dependent child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", and required by the Policy, include Enrollment verification from school.	Was dependent child incapacitated? <input type="checkbox"/> Yes <input type="checkbox"/> No	

AMOUNT OF INSURANCE BEING CLAIMED FOR DEPENDENT

Basic Dep AD&D in force: \$ _____	Supplemental Dep AD&D in force: \$ _____	Dependent benefit is a: <input type="checkbox"/> Flat Amount <input type="checkbox"/> Percentage of Employee's amount If a percentage, please complete amount of employee insurance above.
Dismemberment/Loss of Sight Amount Being Claimed (if applicable under the Policy) List Total Dismemberment Amount Being Claimed: \$ _____		Does Coverage claimed reflect age reduction(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Indicate if any of the following apply to this Dependent: <input type="checkbox"/> Applied for Conversion <input type="checkbox"/> Has been approved for LBO/Accelerated Death Benefits by prior carrier <input type="checkbox"/> Has been approved for Waiver of Premium by prior carrier		

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.

_____ Employer	_____ Address
_____ Signature	_____ Date
() _____ Telephone Number	() _____ Facsimile Number
_____ E-mail address	
_____ Their Authorized Representative: (Please print)	

**GROUP ACCIDENTAL DISMEMBERMENT CLAIM FORM
for EMPLOYEE or DEPENDENT**



PART II - CLAIMANT'S STATEMENT OF ACCIDENTAL DISMEMBERMENT

INSTRUCTIONS: Complete this form if you are applying for 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):
		Basic AD&D: _____ Vol AD&D: _____

Name of Injured: (if different from above)	Age: _____	Relationship to Employee: _____ Spouse _____ Child _____
--	------------	--

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 injuries received: _____

Describe in detail how the accident happened: _____

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

List name/address/phone number of all physicians consulted for the injury: _____

List name/address/phone number of all hospitals consulted: _____

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

Claimant's Name:	Your Date of Birth:	Your Social Security Number:
------------------	---------------------	------------------------------

In what capacity are you making claim? (Note: if other than claimant, attach appropriate legal documents substantiating your authority)

Your Signature:	Date:	Your Telephone Number:
-----------------	-------	------------------------

MEDICAL RELEASE AUTHORIZATION

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 CLAIMANT OR PERSONAL REPRESENTATIVE:	DATE:
--	--------------

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

² All support services offered through Beneficiary Assist are provided by ComPsych®, a national leader in employee assistance programs. ComPsych is not affiliated with The Hartford. Neither The Hartford nor ComPsych® provide financial or legal advice.

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, 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 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 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 with the penalty of 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 are 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

DISMEMBERMENT FILING ONLY



**PART III - ATTENDING PHYSICIAN'S STATEMENT - Certification on Page Two
DISMEMBERMENT/LOSS OF SIGHT/HEARING/SPEECH**

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

Page One

Patient's Name	Date of Birth	Social Security Number	
Address	City	State	Zip Code
On what date did you first examine and treat the patient for this injury? _____ Had patient previously had medical attention for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> 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, solely responsible for the loss? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Note: Please Complete next page for Loss of Speech and/or Hearing.

DISMEMBERMENT FILING ONLY

ATTENDING PHYSICIAN'S STATEMENT DISMEMBERMENT - LOSS OF 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

Facsimile number

Telephone number

Taxpayer's Identification Number

Physician's Signature

Specialty/Degree

Date

Please return completed form(s) and supporting medical records to:

Mail to: The Hartford
Group Life/AD&D Claims Unit
P. O. Box 14297
Lexington, KY 40512-4297
1-888-563-1124 Fax: 1-866-344-9747