Accidental Dismemberment Claim Form 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 6.

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 paper enrollment forms and/or on-line enrollment screen prints, of current and two prior plan years for history of benefit elections and 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 (pages 4-5).

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

- ☐ Attending Physician should complete pages 7 and 8 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, applicable if required under the policy.

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

Clear Form

ACCIDENTAL DISMEMBERMENT CLAIM FORM (Group Life Insurance) EMPLOYEE or DEPENDENT

Mail forms to:
The Hartford Group Life/AD&D Claims Unit
P. O. Box 14299
Lexington, KY 40512-4299
Phone: 1-888-563-1124 Fax: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com

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

(Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly)

Policy Number(s):
Life/ AD&D: _____ AD&D: _____ Business Travel Accident: _____

Employer:

Name of Insured / Employee:

Insured's address: (Street, City, State & Zip Code)

Social Security Number: | Date of Birth: | Date of Death: | Date of Hire: | Effective date of employee's insurance: | ☐ Salaried ☐ Hourly

Branch/Location: | Occupation: | Classification | Premiums paid to date? ☐ Yes ☐ No | Provide employee's actual date last physically at work:

Provide reason employee did not return to work on their next scheduled workday:
☐ Illness ☐ FMLA (provide approval form) ☐ Retirement - Date: _____ ☐ Other (please explain): _____

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

Has the Beneficiary completed a Funeral Home Assignment? ☐ Yes ☐ No
If "Yes," enclose a copy or explain:

TRAVEL INFORMATION – ONLY COMPLETE FOR BUSINESS TRAVEL ACCIDENT CLAIMS

Trip Begin Date: | Scheduled Trip End Date: | Injury sustained during: ☐ Work Activity ☐ Pleasure Activity | Amount of BTA Insurance claimed: $

Date of Accident: | Time of Accident: (hr, min) : ☐ AM ☐ PM | Place of Accident:

Fully describe the circumstances of the Accident and nature of Injuries, if known: (Include incident/police reports as available; attach separate sheet, if necessary)

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: $

Dismemberment/Loss of Sight Amount Being Claimed

List Total Dismemberment Amount Being Claimed
$

Coverage claimed above, reflect age reduction(s)? ☐ Yes ☐ No

Date insurance was discontinued or not in force _____

(Employee's earning as defined in the policy. Attach W-2 if applicable)

Rate of earnings used to calculate benefit amount: _____
☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

Regular hours scheduled to work: (if applicable) _____

Effective date of above reported earnings: _____

Do the earnings include commissions or bonuses? ☐ Yes ☐ No

Indicate if any of the following apply to this Employee:
☐ Applied for Conversion
☐ Has been approved for Long Term Disability
☐ Has been approved for LBO/Accelerated Death Benefits by prior carrier
☐ Has been approved for Waiver of Premium by prior carrier

DEPENDENT INFORMATION - ONLY COMPLETE FOR DEPENDENT CLAIM

Full Name of Insured Dependent | Dependent's Social Security Number | Date of Birth | Relationship to Employee

Residence: (Number, Street, City or Town, Zip Code)

Is Employee Actively at Work? ☐ Yes ☐ No
If no, complete date last worked and reason above

Have premiums been paid to date for this dependent? ☐ Yes ☐ No

Is the dependent child, over the Policy's limiting age? ☐ Yes ☐ No

Is the dependent child a full-time student? ☐ Yes ☐ No If "Yes", and required by the Policy, include Enrollment verification from school.

Is dependent child incapacitated? ☐ Yes ☐ No

AMOUNT OF INSURANCE BEING CLAIMED FOR DEPENDENT

Basic Dep AD&D in force: | Supplemental Dep AD&D in force

Dismemberment/Loss of Sight Amount Being Claimed (if applicable under the Policy)

List Total Dismemberment Amount Being Claimed:

Dependent benefit is a: ☐ Flat Amount ☐ Percentage of Employee's amount
If a percentage, please complete amount of employee insurance above.

Does Coverage claimed reflect age reduction(s)? ☐ Yes ☐ No

Indicate if any of the following apply to this Dependent:
☐ Applied for Conversion
☐ Has been approved for LBO/Accelerated Death Benefits by prior carrier
☐ 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 The Hartford and/or its representative.

Employer | Address

Signature | Date | Their Authorized Representative: (Please print)

( ) Telephone Number | E-mail address | ( ) Facsimile Number

STATEMENT OF CLAIM
FOR ACCIDENTAL DISMEMBERMENT BENEFIT
Claim form for EMPLOYEE or DEPENDENT

Mail forms to:
The Hartford
Group Life/AD&D Claims Unit
P. O. Box 14299
Lexington, KY 40512-4299
Phone: 1-888-563-1124 Fax: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com

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INSURED EMPLOYEE OR MEMBER STATEMENT

Group Policyholder/Employer Name:	Claim Event ID (if known)	Claim ID Number

Group Policy Number(s): Life/AD&D: SR AD&D: Business Travel Accident:

Full Name of Insured *(Employee/Member)*	Social Security Number	Date of Birth

Name of Dependent ***(if claim is for Dependent)***	Relationship to Employee ☐ Spouse ☐ Child	Social Security Number	

Address of Insured ***(Employee/Member) (Number, Street, City, State & Zip Code)***

Are you now wholly unable to work? ☐Yes ☐No	Has a claim been filed? ☐Yes ☐No	If "Yes," what is the status of the claim? _____

On what date did the accident occur? _____ Where did the accident occur? City _____ State _____

If injury was sustained while traveling on policyholder business, please complete the following:

Trip Begin Date: _____ Scheduled Trip End Date:_____

Injury was sustained during: ☐ Work Activity ☐ Pleasure Activity

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:

Describe in detail any chronic disease or physical defect or deformity, if applicable:

I hereby certify that the information provided by me in this Statement of Claim form is true and complete to the best of my knowledge and belief, and that I have read and understand the statements on page 3 of this form.

_____ _____
Signature of Insured ***(Employee/Member)*** Date

Please complete and sign the Authorization to Obtain and Release Information Form on the page 5.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 drug abuse, and mental health; 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, 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 (all entities and individuals listed in this paragraph including The Hartford defined as "Benefits Manager(s)"). *I understand that My Information disclosed to Benefits Managers and re disclosed could include HIV/AIDS, other communicable diseases and mental health records.*

I understand that My Information disclosed to Benefits Managers pertaining to certain alcohol or drug abuse treatment is protected by federal (42 CFR Part 2) and state confidentiality rules and statutes, which prohibit any further disclosure of this information without my express written consent, or as otherwise permitted by such rules and statutes. I understand that a general authorization for the release of medical or other information is NOT sufficient for release of certain types of alcohol or drug abuse treatment records.

(Continue to next page)

Therefore:

☐ **If any of my records contain information about alcohol or drug abuse, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the benefits program. I understand that the federal rules restrict any use of the Information to criminally investigate or prosecute any drug or alcohol abuse patient.**

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 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, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself.

If I change my mind about this Authorization before that time is up, I can tell my Records Holders and The Hartford in writing that I do not want them to share any more information with other parties. If I revoke my Authorization by telling them in writing to stop sharing information with other parties, it will not change any actions they took before I revoked my permission. If I do not sign this Authorization, it will not affect how my health care providers treat me. However, if I do not sign, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in 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.

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 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 _____

DISMEMBERMENT FILING ONLY

THE HARTFORD

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

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? ☐ 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

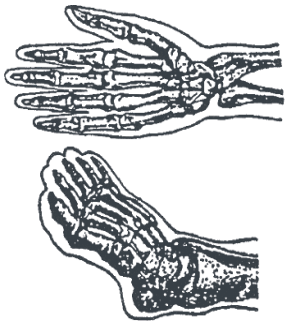
Name of Surgeon

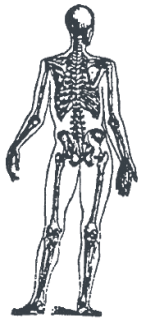
Name and address of Hospital From: _____ To: _____

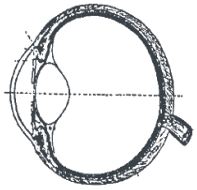
Was the injury described above, of itself, and independent of all other causes, solely responsible for the loss? ☐ Yes ☐ No
If "No", give the particulars of any contributing cause or causes:

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

If the injury described above caused an amputation or loss of body usage, is this amputation or loss irrecoverable? ☐ Yes ☐ No
If "No", please explain:







Please indicate location of amputation or area of injury on the left side chart.
Add any necessary comments below.

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

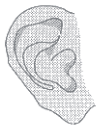
Right eye: _____	Corrected _____	Uncorrected
Left eye: _____	Corrected	Uncorrected

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

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

DISMEMBERMENT FILING ONLY

ATTENDING PHYSICIAN'S STATEMENT DISMEMBERMENT - LOSS OF HEARING/SPEECH



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:

The Hartford
Group Life/AD&D Claims Unit
P. O. Box 14299
Lexington, KY 40512-4299
Fax: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com