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

Employer/Policyholder Statement

Hartford Life and Accident Insurance Company

In furnishing this form, The Hartford® does not waive any of its rights or defenses nor admit liability. The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Employer/Policyholder Responsibilities:

1) Complete, sign and date this form. For assistance with completing this form, please call (866)547-4205. This form is only required once per event, regardless of the number of additional/follow-up claim submissions.
2) Provide a copy of the employee/member's enrollment form/record and beneficiary designation (if applicable).
3) Submit the form and required documentation to The Hartford Supplement Insurance Benefit Department, PO Box 99906, Grapevine, TX 76099; or fax to (469)417-1952.
4) If an employee/member is enrolled for any other group coverage through The Hartford for which benefits may be available as a result of the covered event, please encourage and/or work with the employee/member to submit the appropriate claim(s).

EMPLOYER/POLICYHOLDER INFORMATION

Employer/Policyholder Name	**Policy Number**

EMPLOYEE/MEMBER (EE) INFORMATION

EE Name (First MI Last)	**SSN or Tax ID #**	**Date of Birth**	**Date of Death** (If applicable)

Class/Location*	**Date of Hire***	**Hours Worked/Week***	**Is EE actively working?*** ☐ Yes ☐ No	**Date Last Worked*** (If applicable)

If the EE is not working or working less than the minimum hours, indicate why: *

☐ Medical/Protected Leave (FMLA) ☐ Personal Leave ☐ Layoff ☐ Termination/Retirement ☐ Other (Explain in Add'l Info section)

If the EE died as a result of the event, is a beneficiary designation on file for this insurance?

☐ Yes ☐ No; *If Yes, a copy must be provided*

*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.

ON-THE-JOB ACCIDENT/INJURY INFORMATION – COMPLETE IF EE WAS HURT WHILE WORKING

Date of Accident	**Location of Accident**	**Will/has a worker's comp (or equivalent) claim been filed?** ☐ Yes* ☐ No

***If Yes, provide contact information for worker's comp/equivalent carrier:**

ACCIDENT INSURANCE (AI) INFORMATION – COMPLETE IF EE HAS AI

Effective Date for EE Insurance	**Effective Date for Dep. Insurance**	**Premium Paid Through Date**	**What % of premiums are paid pre-tax?** _____%

Current Coverage Tier (As elected by EE)
☐ EE Only ☐ EE + Spouse/Partner ☐ EE + 1 Dep ☐ EE + Child(ren) ☐ Family

Current Plan Election (As elected by EE)

HOSPITAL INDEMNITY (HI) INSURANCE INFORMATION – COMPLETE IF EE HAS HI

Effective Date for EE Insurance	**Effective Date for Dep. Insurance**	**Premium Paid Through Date**	**What % of premiums are paid pre-tax?** _____%

Current Coverage Tier (As elected by EE)
☐ EE Only ☐ EE + Spouse/Partner ☐ EE + 1 Dep ☐ EE + Child(ren) ☐ Family

Current Plan Election (As elected by EE)

CRITICAL ILLNESS/SPECIFIED DISEASE (CI) INSURANCE INFORMATION – COMPLETE IF EE HAS CI

Effective Date for EE Insurance	**Effective Date for Dep. Insurance**	**Premium Paid Through Date**	**What % of premiums are paid pre-tax?** _____%

Current Coverage Tier (As elected by EE)
☐ EE Only ☐ EE + Spouse/Partner ☐ EE + 1 Dep ☐ EE + Child(ren) ☐ Family

Current Plan Election (As elected by EE)

ADDITIONAL INFORMATION – USE THIS SPACE TO PROVIDE ADDITIONAL INFORMATION, AS NEEDED

EMPLOYER/POLICYHOLDER CERTIFICATION

By signing below, I hereby certify that: 1) the information provided on this form is true and complete according to the records of the employer/policyholder; 2) I have read and understand the "Important Notice – Fraud Warning Statements" that applies to the situs state of the employer/policyholder; and 3) I agree that this information is subject to audit by The Hartford® and/or its representative.

Signature of Policyholder's Authorized Representative	**Date of Signature**	
Printed Name of Authorized Representative	**Title/Position of Authorized Representative**	
E-mail Address	**Phone Number**	**Fax Number**

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Important Notice – Fraud Warning Statements

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Please read the statement that applies to your state of residence prior to signing the claim form and prior to signing this form.

For residents of all states EXCEPT Arizona, 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 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 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 or 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 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 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.

Signature	**Date of Signature**