# 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 5.

**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 4).

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

- ☐ Attending Physician should complete pages 6 and 7 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**
**1-888-563-1124 Fax: 1-866-954-2621**
**E-Mail to: gbclaimcslife@thehartford.com**

THE HARTFORD

**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)**

Group Policy Numbers:
Life/ AD&D:_____ Voluntary AD&D:_____ Group Travel: _____

Employer:

Name of Insured /Participant:

Social Security Number:

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

Date of Birth:

Branch/Location:

☐ Salaried ☐ Hourly

Date of Hire:

Effective date of employee's insurance:

Premiums paid to date? ☐ Yes ☐ 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:
☐ Illness ☐ FMLA (provide approval form) ☐ Retirement - Date:_____ ☐ 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:
$

**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

**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 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 Hartford Life Insurance Company or Hartford Life and Accident Insurance Company and/or its representative.

Employer

Address

Signature

Date

Their Authorized Representative: (Please print)

( )
Telephone Number

E-mail address

( )
Facsimile Number

## Group Accidental Dismemberment Claim Form for EMPLOYEE or DEPENDENT

THE HARTFORD

**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 Iniured Person: (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 deceased 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 beneficiary, attach appropriate legal documents substantiating your authority)

| Your Signature: | Date: | Your Telephone Number: ( ) |
|---|---|---|

**Please complete and sign the Authorization to Obtain and Release Information Form on the next page**

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.

## AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

**To:** Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, 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, and to communicate telephonically or electronically with The Hartford's representatives about, any and all of the following personal, private, 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 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 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 and/or request for accommodation. 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 restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or 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 or other audits or reviews; (ii) to the administrator 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 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, 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; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) 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, respond to regulatory complaints, 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 Authorized Representative | Date (Valid for 2 years) | Relationship to Insured ***(if signed by Authorized Representative)*** |
|---|---|---|
| | | |

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries and their affiliates

# 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, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon Pennsylvania, Puerto Rico, Tennessee 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 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 nformation 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.

**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 _____

## 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

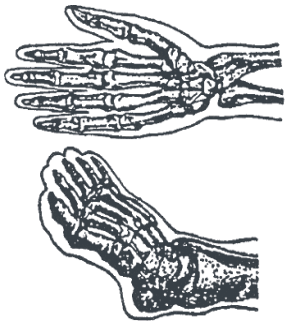
Name of Surgeon

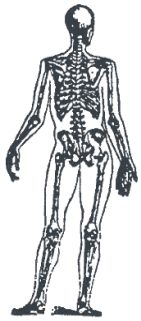
Name and address of Hospital From: _____ To: _____

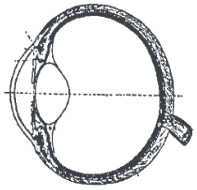
Was the injury described above, of itself, and independent of all other causes, solely responsible for the loss? ☐ Yes ☐ No
If "No", give the particulars of any contributing cause or causes:

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).

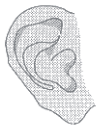
| | | | |
|---|---|---|---|
| Right eye: _____ | Corrected _____ | Uncorrected | |
| Left eye: _____ | Corrected | Uncorrected | |

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** **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:**

**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**