STATEMENT OF CLAIM
HOSPITAL ACCIDENT INCOME PLAN ASSOCIATION

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

THE HARTFORD

INSTRUCTIONS: Mail the completed form, along with the Insured Person's enrollment forms, copy of itemized hospital bill [Form UB92], police accident or incident report concerning the accident, to: _____
The benefits decision will be made by The Hartford. _____
If you have a question on the claim decision, please contact The Hartford's Life Customer Service Unit at 1-888-563-1124.

Clear Form

STATEMENT OF ADMINISTRATOR

Name of Primary Insured	Policy Number	Plan of Insurance
Name of Insured	Insured's Date of Birth (mm/dd/yy)	Insured's Social Security Number
Address of Insured	Telephone number:	Date of Injury or Loss: (mm/dd/yy) / Insured's Effective Date: (mm/dd/yy)
Effective date of insured's Insurance Increase, if applicable (mm/dd/yy)	Amount of Increase: $	Premium Paid to Date: (mm/dd/yy) / Indicate Plan Type (when applicable)
Optional Rider(s) Amount,and effective date(s), if applicable: (mm/dd/yy) (Please attach Certificate Schedule when possible		Amount of Insurance in Force at Time of Loss $
If claim is being filed for an eligible dependent, give dependent's insurance effective date	Dependent's Date of Birth: (mm/dd/yy)	Relationship: / Dependent's Social Security Number:

Date _____ Signed for administrator by _____

STATEMENT OF CLAIM

Full Name of Primary Insured	Date of Birth	Social Security Number

Name of Policyholder or Participating Organization

Address of Policyholder or Participating Organization

Patient's Name (if not Primary Insured) ☐ Child ☐ Spouse

Date of Birth	Social Security Number	☐ Male ☐ Female

Is the patient a child 18 or over? ☐ Yes ☐ No ☐ Single ☐ Married Is the child full-time student? ☐ Yes ☐ No

If "Yes", give the name and address of the College or University

When did injury occur? Date _____, 20_____ at _____ ☐ P.M. ☐ A.M.

Describe fully how and where accident occurred.

Describe nature and onset date of injury

What is the treating physician's or surgeon's name and address?

If hospitalized, give name and address of hospital.

Hospital Confinement: From_____ , 20_____ at _____ ☐ P.M. ☐ A.M. To _____, 20 _____at _____ ☐ P.M. ☐ A.M.

Please be sure to read and sign page three of this form.

ATTENDING PHYSICIAN'S STATEMENT - HOSPITAL INCOME CLAIM - GROUP OR INDIVIDUAL

Patient's Name and Address | Age

Diagnosis and Concurrent Conditions
(If Fracture or Dislocation, describe Nature and Location)

When did symptoms first appear or accident happen? Date _____

When did patient first consult you for this condition? Date _____

Was Patient refered to you by another doctor? ☐ Yes ☐ No If "Yes", Name and address.

Has patient ever had same or similar condition? ☐ Yes ☐ No
(If "Yes," state when and describe.)

Nature of surgical procedure, if any. Date performed _____ CPT Code _____
(Describe fully)

If performed in hospital, give name of hospital. ☐ Inpatient ☐ Outpatient

Give dates of other medical (non-surgical) treatment, if any
Office _____
Home _____
Hospital _____
Nursing Home _____

Is patient still under your care for this condition?
If "No," give date your services terminated. ☐ Yes ☐ No Date _____

Is condition due to injury? ☐ Yes ☐ No
If "Yes," explain.

Has patient been treated for this illness/injury in the past 12 months? ☐ Yes ☐ No
If "Yes," give dates. Dates of treatment _____ to _____

Date	Signature (Attending Physician)	Degree	Telephone Number

Street Address	City or Town	State or Province	Zip Code

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*)

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, 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 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, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to 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.

Signature _____ Date _____