

# Group Life and Accidental Death Claim Forms for Employee or Dependent



## IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

### To the 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.

**NOTE:** If you enrolled and are covered for any other group benefits that you may qualify for through The Hartford, please contact your employer and submit the claim accordingly. If you are uncertain of other coverage, please contact your employer for assistance.

**The information below constitutes a complete claim filed with The Hartford for purposes of claiming Basic, Supplemental and/or Dependent coverage.**

### Part I - Beneficiary's Statement (needed for both Life or Accidental Death claims)

- Form is to be completed in its entirety, indicating your current address, date of birth and Social Security Number.
- A certified copy of the Death Certificate stating cause and manner of death must be attached to this form.
- Return this form to The Hartford, at the address shown below.

The Company reserves the right to require or to obtain further proof of information should it be deemed necessary.

**The information below constitutes a complete claim filed with The Hartford for purposes of claiming Basic, Supplemental and/or Dependent AD&D coverage.**

### Part II - Claimant's Statement (needed only for Accidental Death claims).

- Must be completed by claimant or beneficiary claiming a death due to an accident. Please sign the Authorization to Obtain and Disclose Information, page 6.
- Additionally, please furnish any police or motor vehicle reports, autopsy/toxicology, newspaper accounts, or other pertinent information regarding the claim for accidental death.

The Company reserves the right to require or to obtain further proof of information should it be deemed necessary.

### Miscellaneous - All Claims

- If the claim proceeds are payable to an Estate, Part II must be completed by the Executor or Administrator of the Estate. An official certificate of such person's legal appointment and qualification must be attached to this form. Please include the Estate Tax Identification Number. If none available, please explain.
- If any designated beneficiary is a minor, Part II must be completed by a custodian or guardian. Include the minor's social security number, also, please include a copy of the minor's birth certificate. An official certificate of the guardian's legal appointment and qualification of the minor's estate or property must also be included, if applicable.
- 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.
- Foreign Death - Include both the Official Death Certificate and the Death of American Citizen Abroad form. Please note that additional documents may be required upon claim review.

Mail complete claim to: The Hartford  
Group Life Claims  
P. O. Box 14299  
Lexington, KY 40512-4299  
Fax to: 1-866-954-2621  
E-Mail to: gbclaimclife@thehartford.com

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company. Home Office is Hartford, CT. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.

**General Information**  
**Group Life and/or Accidental Death Claim Form**  
**EMPLOYEE or DEPENDENT**

**Mail forms to:**  
**The Hartford**  
**Group Life Claims**  
**P. O. Box 14299**  
**Lexington, KY 40512-4299**  
**1-888-563-1124 Fax: 1-866-954-2621**  
**E-Mail: gbclaimclife@thehartford.com**



<b>Group Policyholder/Employer Name:</b> _____			
Group Policy Number(s): Life/AD&D: _____ AD&D: _____ Business Travel Accident: _____			
Name of Insured Employee/Retiree/Participant:		Date of Birth:	Social Security Number:
Name of Deceased or Injured (complete for Dependent claim only)		Date of Birth:	Social Security Number:
Relationship of the Dependent to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Age:	Claim ID Number:	Claim Event ID (if known):

**PART I - Beneficiary's Statement**

**Under penalties of perjury, I certify that:**

- (1) the number shown on this form is my correct taxpayer identification; and
- (2) I am not subject to a back-up withholding, because, (a) I am exempt from back-up withholding; or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends; or (c) the IRS has notified me that I am no longer subject to back-up withholding; and
- (3) I am a U.S. person (including a U.S. resident alien).

**Certification Instructions:** You must cross out item (2) above, if you have been notified by the IRS that you are currently subject to back-up withholding, because, you have failed to report all interest and dividends on your tax return.

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: <input type="checkbox"/> U.S. citizen <input type="checkbox"/> U.S. resident <input type="checkbox"/> Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	Telephone Number: Day: (    )    Evening: (    )	
Personal Cell Telephone Number: (    ) _____ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No and/or request this by e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No Please initial: _____ to confirm your election		
<b>The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.</b>		
<b>By signing below:</b>		
<ol style="list-style-type: none"> <li>(1) <b>I Hereby Certify and Agree</b> that I have read and understand the IMPORTANT NOTICE on page 4 of this claim form package.</li> <li>(2) <b>I understand and Agree</b> that payment of the claim proceeds according to any alternate mode of settlement specified in the policy will only be made if the Company receives a written request for such alternate method of payment from me prior to the payment of the claim proceeds.</li> <li>(3) <b>I understand and Agree that if I receive claim proceeds which are not due to me, I will reimburse The Hartford.</b></li> </ol>		
Signature: <b>X</b>	Date:	E-mail address:

**Group Life and/or Accidental Death Claim Form  
for EMPLOYEE or DEPENDENT**



<b>Claimant's Statement of Accidental Death (complete only if death was due to an accident)</b>		
<b>INSTRUCTIONS:</b> Complete this form if you are applying for death benefits due to an accident. If a question does not apply, please mark "N/A."		
Group Policyholder/Employer Name: _____		
Group Policy Number(s):	Life/AD&D:	AD&D: Business Travel Accident
Name of Insured/Employee:		Social Security Number:
Name of Deceased: (if different from above)	Age:	Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Has a Workers' Compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		
Did accident result in death? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what date? _____		
If injury was sustained while traveling on policyholder business, please complete the following:		
Trip Begin Date: _____ Scheduled Trip End Date: _____		
Injury was sustained during: <input type="checkbox"/> Work Activity <input type="checkbox"/> Pleasure Activity		
Describe in detail how the accident happened:		
Name and address of law enforcement agency involved: <i>(Please submit copy of Police Accident Report and/or Case Number)</i>		
List name/address/phone number of all physicians consulted for the injury/death:		
List name/address/phone number of all hospitals consulted:		
Did the deceased have any chronic disease or physical defect or deformity? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", describe in detail:		
Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide name/address/telephone number of coroner, if known:		
Was an inquest held? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", verdict:		

Please complete and sign the Authorization to Obtain and Disclose Information, pages 5 and 6.

**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

## 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.**