GROUP ACCIDENT CLAIM FORM

Accident Prevention Benefit

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.

Employee/Member/Claimant Responsibilities:

1) Complete, sign and date this form. For assistance with completing this form, please call (866)547-4205.
2) Provide a copy of the exam notes, exam/screening/procedure results, the bill for the exam/screening/procedure, proof of completion of a licensed/accredited program, or other proof. The claimant is responsible for any fees charged for proof requirements.
3) Submit the form and required documentation to The Hartford Supplemental Health Benefit Department, PO Box 99906, Grapevine, TX 76099; or fax to (469)417-1952.

EMPLOYER/POLICYHOLDER INFORMATION

Employer/Policyholder Name	**Policy Number**

EMPLOYEE/MEMBER INFORMATION

Employee/Member Name (First MI Last)	**SSN or Tax ID #**	**Gender** ☐ Male ☐ Female ☐ Other
Address (Street, City, State & Zip)		**Date of Birth**
E-mail Address	**Phone Number**	**Cell/Mobile Number**
May we have your authorization to deliver confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No **Via email?** ☐ Yes ☐ No; If Yes to either personal cell phone or email, please initial here to confirm your response: _____		
Does the employee/member have major medical insurance or other primary health insurance? ☐ Yes* ☐ No	***If Yes, provide name of insurance carrier and policy number:**	
Is the employee/member currently actively working?† ☐ Yes ☐ No; *If No, provide date last worked and reason:*		**Hours Worked/Week†**

†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.

DEPENDENT INFORMATION – COMPLETE IF THIS CLAIM IS FOR A DEPENDENT OF THE EMPLOYEE/MEMBER

Dependent Name (First MI Last)	**SSN or Tax ID #**	**Date of Birth**	**Relationship** (To employee/member)
Is the dependent insured under Medicaid or any similar Title XIX program? ☐ Yes ☐ No	**Is the child incapacitated/ disabled?** (If applicable) ☐ Yes ☐ No	**Is the child married or in a partnership?** (If applicable) ☐ Yes ☐ No	
Is the child a full-time student? (If applicable) ☐ Yes* ☐ No	***If Yes, provide name and contact info for the school:**		

ACCIDENT PREVENTION BENEFIT INFORMATION

A copy of exam notes or exam/screening/procedure results, a bill for the exam/screening/procedure, proof of completion of an appropriately licensed or accredited program, or other proof must be submitted with this form.

Please check the exam, screening or program for which the claim is being filed: (Check all that apply)

- ☐ Dental exam
- ☐ Eye exam
- ☐ Hearing exam
- ☐ Annual physical
- ☐ Sports physical
- ☐ Well-child exam
- ☐ Serum cortisol test (for stress levels)
- ☐ Employer-sponsored wellness or biometric screening
- ☐ Emotion management or stress reduction program
- ☐ Driver safety and training program
- ☐ Motorcycle safety and training program
- ☐ Workplace safety and training program
- ☐ Other (must be covered by applicable policy): _____

Date the Exam/Screening was Performed or Date the Program was Completed	**Provider/Physician Phone Number**
Provider/Physician Name	**Provider/Physician Address**

CLAIMANT INFORMATION – COMPLETE ONLY IF THE CLAIMANT **IS NOT** THE EMPLOYEE/MEMBER

Claimant Name (First MI Last)	**Phone Number**	**Cell/Mobile Number**
Complete Mailing Address (Street/Box, City, State & Zip)	**E-mail Address**	
May we have your authorization to deliver confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No **Via email?** ☐ Yes ☐ No; If Yes to either personal cell phone or email, please initial here to confirm your response: _____		

CLAIMANT CERTIFICATION

By signing below, I hereby certify that: 1) The information provided on this form is true and complete to the best of my knowledge and belief; and 2) I have read and understand the "Important Notice–Fraud Warning Statements" that applies to my state of residence.

Claimant Signature	**Date of Signature**

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

Important Notice – Fraud Warning Statements

Hartford Life and Accident Insurance Company

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

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, 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 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 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.

Signature	**Date of Signature**