

**HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**



Proof of Death - Association/Affinity Term Life

INSTRUCTIONS: In furnishing this form, THE COMPANY does not waive any of its rights nor admit liability. This form is to be completed by the Association and beneficiary and submitted with an official death certificate bearing the raised seal or other Certifying device of the governmental agency issuing the Certificate. The form, death certificate and Certificate of Insurance should be mailed to: **The Hartford, P.O. Box 14299, Lexington, KY 40512-4299.**

STATEMENT OF ADMINISTRATOR

Name of Association/Affinity Group:		Plan of Insurance:	Policy Number:	
Name of Insured:		Insured's Social Security Number:	Insured's Date of Birth : (mm/dd/yy)	
Address of Insured: (Street, City, State & Zip Code)			Date of Death (mm/dd/yy)	
Effective Date of Insured's original insurance: (mm/dd/yy)	Effective Date of Insured's insurance increase, if applicable: (mm/dd/yy)	Amount of Increase: \$	Amount of Insurance: in force at Death: \$	Insured Paid to Date: (mm/dd/yy)
If claim is being filed for an eligible dependent, give dependent's insurance effective date: _____ (mm/dd/yy)				
Dependent's Name:	Dependent's Date of Birth:	Relationship:	Optional Rider(s), Amount(s) and effective date(s), if applicable. Amount of Rider: \$ _____ Effective Date: _____	
Date: _____		Signed for Administrator by: _____		

STATEMENT OF BENEFICIARY

When did deceased first complain of last illness?		When did deceased first consult a physician for last illness?		
State names and addresses of physician(s) who attended the deceased and hospital(s) and institution(s) where deceased was treated during the last illness and during five years prior thereto:				
Physician(s), Hospital(s), Institution(s):	Address:	Date(s):	Disease/Condition	

BENEFICIARY CERTIFICATION

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.

By signing below:

- (1) **I Hereby Certify and Agree** that I have read and understand the IMPORTANT NOTICE on page 2 of this claim form package.
- (2) **I understand and Agree** 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.

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 (Please provide a W-8BEN form)			
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 Please initial here: _____ to confirm your election			
The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.			
Signature: X		Date:	E-mail address:

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 California, Colorado, Florida, Kentucky, Maine, 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 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 an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

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.

Signature

Date

