Clear Form

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

THE HARTFORD

PROOF OF LOSS - ACCIDENTAL DEATH ASSOCIATION/AFFINITY

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 Administrator and beneficiary and submitted with 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, Life Claims, P.O. Box 14299, Lexington, KY 40512-4299.** Additionally, please furnish any newspaper accounts, police or motor vehicle reports, autopsy/toxicology or other pertinent information regarding the claim for accidental death.

STATEMENT OF ADMINISTRATOR (Please attach Certificate of Benefit Schedule if possible)

Name of Association/Affinity Group:	Plan of Insurance:	Policy Number:
Name of Insured:		Insured's Social Security Number:
Address of Insured: *(Street, City, State & Zip Code)*		Insured's Date of Birth: / /

Date of Loss: / /	Effective Date of Insured's original Insurance: / /	Effective Date of Insured's Insurance increase, if applicable: / /
Amount of increase:	Insured paid to date: / /	Amount of Insurance in Force at Death:

If claim is being filed for an eligible dependent, give dependent's insurance effective date: / /

Date of Birth of Dependent: / /	Relationship:

Date _____ Signed for Administrator by: _____

STATEMENT OF BENEFICIARY

Date of birth for deceased *(Day/Month/Year):* / /	When did accident happen? / /	Date of death *(Day/Month/Year)* / /

Place of death (City, State, Zip):

Where did accident happen? (Specify address or location of accident)

Describe in detail how the accident happened:

Describe fully injuries received:

Please be sure to read and sign all appropriate pages

Statement of Beneficiary (Continued)

Did the injured have any chronic disease (please list below):
Name/Address/Telephone Number of law enforcement agency involved. (Please submit a copy of the Police Accident Report, case number and/or contact information):
Name/Address/Telephone Number of all medical facilities where treatment was received for the injury. (Please provide available report(s):
List name/address/phone numbers of all physicians consulted from the date of the injury to the date of loss:
Was an inquest held? ☐ Yes ☐ No If "Yes", please provide a copy.
Was an autopsy performed? ☐ Yes ☐ No If "Yes", by whom? or provide a copy, if available.

BENEFICIARY CERTIFICATION:
(Note: if any beneficiary entitled to benefits is deceased, provide a Death Certificate copy)

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 3 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: ☐ U.S. citizen ☐ U.S. resident ☐ 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? ☐ Yes ☐ 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

Please enclose the completed claim form along with the Insured Person's enrollment forms, beneficiary designation (and all changes thereto), certified copy of death certificate, police accident or incident report, and newspaper articles concerning the accident. The benefits decision will be made by The Hartford. If you have a question on the claim decision, please contact The Hartford's Customer Service Unit at 1-888-563-1124.

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*)

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company.