Clear Form

HARTFORD FIRE INSURANCE COMPANY
HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

THE HARTFORD

MAINE MUNICIPAL ASSOCIATION VOLUNTEER FIREFIGHTER NOTICE OF CLAIM

A claim is being filed for: (Choose one or both of the following)

☐ Medical Benefits: Forward Questions/Claims to: Hartford Life Claim Office (Blanket Lines Unit), One Hartford Plaza T-14, Hartford, CT 06155
Phone Number: (800) 678-6702 Fax Number: (866) 954-3993

☐ Disability Benefits: Forward Questions/Claims to: P.O. Box 14295, Lexington, KY 40512-4295
Phone Number: (888) 232-5340 Fax Number: (866) 913-4044

Claim Instructions:

The Policyholder should: Complete Sections I and III
The Claimant should: Complete Sections II-A, II B (if filing a disability claim), III, IV-A and V
The Attending Physician should: Complete Section IV-B

Section I - Policyholder Information - To be completed by Fire Commanding Officer

Policyholder Name		Policy Number
Policyholder Address		Commanding Officers Phone Number ( )
Claimant (Injured Party) Name	Claimant Date of Birth	Claimant Social Security Number
Claimant Gender ☐ Male ☐ Female	Claimant Insured Person Status ☐ Volunteer ☐ Junior Firefighter ☐ Firefighter Auxiliary ☐ Other _____	
Claimant Address (Street, City, State and Zip Code)		Claimant Phone Number ( )
Date of Accident _____ mm/dd/yyyy	Time of Accident _____ hh:mm ☐ AM ☐ PM	Place of Accident

Complete description of Accident

Indicate injured body part(s)

Did the injury result from firefighting training or an actual fire fighting call? ☐ Firefighting Training ☐ Firefighting Call

Have you had this condition previously? ☐ Yes ☐ No	Date Sickness first commenced

Nature of Sickness (if applicable)

Note - Please also include a copy of the Incident Report (if available)

Policyholder Certification Signature Required:

I hereby certify the Claimant is a member of the group insured under the above Policy and the Injury/Sickness was sustained under adequate supervision while participating in an official Covered Activity.

Title of Commanding Officer	Signature of Commanding Officer	Date

Section II-A Claimant Information - To be completed by Claimant if filing a medical claim.

If filing a claim for Medical Benefits:

- Submit itemized medical bills to:
  Hartford Life Claim Office (Blanket Lines Unit), One Hartford Plaza T-14, Hartford, CT 06155
- Sign the Claimant Certification statement listed below

Claimant Certification Signature Required:

I certify the Injury and/or Sickness information provided by the Policyholder in Section I to be true and accurate to the best of my

Signature of Claimant _____ Date _____

Section II-B Claimant Information - To be completed by Claimant if filing a disability claim

Normal Occupation (regular job)	Normal Occupation Work Hours

Name of Normal Occupation Employer	Contact Phone Number ( )
Address of Normal Occupation Employer	**Contact Fax Number ( )**

Contact Name for Normal Occupation Employer	Exact duties unable to perform - Normal occupation

Date last worked Normal Occupation Employer	Date returned to work - Normal Occupation Employer ☐ Full Duty ☐ Light Duty

Verification of Earnings - You must submit proof of earnings.
Attach payroll summary showing pay and hours worked for the 12 months prior to disability. **Your claim will be delayed if you do not submit complete proof of hours worked and your earnings prior to disability.**

Attending Physician's Name	Attending Physician's Phone Number ( )
Attending Physician's Address	**Attending Physician's Fax Number ( )**

Were you treated in the emergency room? ☐ Yes ☐ No If so, name of hospital and date.

Date

Do you have disability (loss of wages) or sick pay coverage through? (Check all that apply)

☐ Your Normal Employer ☐ Worker's Compensation ☐ Other

Attach a copy of check or letter advising of payment amount

I understand that if I perform work of any kind during any period the Hartford has approved my disability claim, I must report all details to The Hartford immediately.

Claimant Certification Signature Required:

I certify the above information and the Injury and/or Sickness information provided by the Policyholder in Section I to be true and accurate to the best of my knowledge.

Signature of Claimant _____ Date _____

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

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 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 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 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.

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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

_____ _____

Signature Date

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.

Section IV - Attending Physician's Statement for Medical and Disability Services
(The patient is responsible for the completion of this form without expense to Company)

THE HARTFORD

Section IV-A To be completed by the Claimant

Name of patient	Social Security Number	Date of Birth

Address of patient *(Street, City, State or Province & Zip Code or Postal Code)*

Name of policyholder	Policy Number

I hereby authorize release of information on this form by the below named physician for the purpose of claim processing.

Signed *(Patient)* _____ *Date* _____

Section IV-B To be completed by the Physician

Claimant Name	Social Security Number	Date of Birth

Diagnosis and Concurrent Conditions (ICD code) *(If fracture or dislocation, describe nature and location.)*

Is treatment due to ☐ Sickness ☐ Accident

When did symptoms first appear or accident happen? Date: _____

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

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

Nature of surgical procedure, if any, (describe fully) performed CPT Code _____

Is patient still under your care for this condition? ☐ Yes ☐ No Date: _____

Did you refer patient to another physician? ☐ Yes ☐ No

If "Yes", Name, address, telephone number. _____

How long was or will patient be continuously unable to work at **Normal Occupation*?** **From** _____ **Thru** _____

How long was or will patient be able to perform some but not all duties of his **Normal Occupation***? **From** _____ **Thru** _____

***LIMITATION** **(If there is a limitation, check**
☐ Standing ☐ Climbing ☐ Bending ☐ Use of Hands ☐ Sitting
☐ Walking ☐ Stooping ☐ Lifting ☐ Psychological ☐ Other *(State which)* _____

To your knowledge does patient have other health Insurance or health plan coverages? ☐ Yes ☐ No
If "Yes", identify.

Attending Physician's Name: *(Please print or type.)*		Telephone Number ( )
License Number		Fax Number ( )
Street address (Street, City, State & Zip Code)		
Social Security Number or E.I.N.	Degree	Specialty

Signature _____ Date Signed _____

Section V

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To: Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, 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, and to communicate telephonically or electronically with The Hartford's representatives about, any and all of the following personal, private, 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 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 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 and/or request for accommodation. 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 restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or 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 or other audits or reviews; (ii) to the administrator 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 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, 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; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) 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, respond to regulatory complaints, 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 or Authorized Representative	Date (Valid for 2 years)	Relationship to Insured (*if signed by Authorized Representative*)