THE HARTFORD

Clear Form

PROOF OF LOSS - ACCIDENTAL DEATH

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

Name of Policyholder			Policy Number
Name of Insured	Address		Social Security Number
Class	Occupation	Date last Worked	Principal Sum

Rate of Base Earnings (Exclude overtime, commissions, bonuses, etc.)
☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

Date employed	Date Insurance Effective	Dependent's Effective Date	Termination Date (if applicable)

If insurance is terminated, please explain reason:

Was injury sustained in connection with any employment? ☐ Yes ☐ No If "Yes," please explain:

Mail benefit check to: ☐ Employer or ☐ Beneficiary with copy to Administrator/Employer

I hereby certify that the information provided to me is true and complete according to the records of the Policyholder. I agree that this information is subject to audit by The Hartford and/or its representatives.

Date _____ Signature of authorized representative _____ Title _____

Address _____ Phone _____

STATEMENT OF BENEFICIARY

Name of Beneficiary	Address	Age	Social SecurityNumber

Fully describe the accident (include what, when, where and how it occurred). Use a separate sheet of paper, if necessary)

To: Any physician, medical practitioner, hospital, clinic or other medical or medically-related facility or provider of medical or dental services or supplies, and any employer, group policyholder, or contract holder or insurer.

I authorize you to release to The Hartford or its representatives any and all information you may have about the mental and physical history, condition and treatment, and the wages and insurance coverage of _____ (deceased).

I understand the information obtained by the use of the Authorization will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by The Hartford to any person or organization EXCEPT to reinsuring companies, Medical Information Bureau, Inc., group policyholder, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize. For the purpose of disclosing information, I understand that this authorization is valid for a period of one year.

I know that I may request to receive a copy of this authorization.

If this authorization is given in connection with a claim for health benefits, disability or life insurance benefits, I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original.

Signature of Beneficiary _____ Beneficiary Telephone Number _____ Relationship to Deceased _____ Date _____

Beneficiary must read and sign Page 2 of this form

For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, Oregon, and Virginia: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

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 New Jersey, Arkansas, New Mexico, and Louisiana: 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 an insurance policy is subject to criminal and civil penalties.

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 thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: "ANY PERSON WHO KNOWINGLY PRESENTS A 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."

_____ _____

Signature Date

Mail the completed claim form along with the Insured Person's enrollment forms, beneficiary designation (and all changes thereto), certified copy of death certificate (photocopies are unacceptable) and newspaper articles concerning the accident to: The Hartford, Group Life Claims, P. O. Box 2999, Hartford, CT 06104-2999. **If you have a question on the claim, or would like to appeal the decision, please contact our Customer Service Unit at 1-888-563-1124.**