HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

STATEMENT OF CLAIM FOR SHORT TERM RECOVERY

THE HARTFORD

INSURED MEMBER - FILL IN THIS PORTION COMPLETELY

Certificate Number _____

INSURED'S STATEMENT

(IF SPACE IS NOT ADEQUATE IN ANY BLOCK, USE SEPARATE PAGE)

Primary Insured's Name | Birth Date | Sex ☐ Male ☐ Female

Address: (Street, City, State & Zip Code)

Email Address:

Personal Cell Telephone Number:( ) Alternate Telephone Number: ( )

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No

Signature: Date:

Claim is for ☐ Self ☐ Spouse ☐ Other | Relationship: | Patient's Name if other than Primary

Birth Date: | If claim is being filed for an eligible dependent, give dependent's insurance effective date.

Describe nature of injury or sickness requiring hospital confinement or outpatient surgery.

If injury, how and where did it occur?

Date injury or sickness began: | Date of first treatment for this condition:

Name of attending physician:

Address of attending physician:

Has the patient had the same or similar condition during the 6 months prior to confinement? ☐ Yes ☐ No
If "Yes," when? _____

Please indicate the periods of hospital care/confinement for which benefits are being paid:
From _____ To _____ From _____ To _____ From _____ To _____

List all physicians consulted for care of this or similar condition during the 6 months prior to confinement, please include your primary care physician

NAME	ADDRESS	PHONE NUMBER	PERIOD TREATED
		( )	From To
		( )	From To
		( )	From To
		( )	From To

List all hospitals/facilities where confined for care of this or similar condition during the 6 months prior to confinement:

NAME	ADDRESS	PHONE NUMBER	PERIOD CONFINED
		( )	From To
		( )	From To
		( )	From To

Complete for claims of Recovery Benefit(s).

Dates for which Short Term Recovery Care as needed: _____ _____ _____ _____

Please select Applicable Recovery Services Received:

☐ Skilled Nursing Care (provided by a registered Nurse (RN); Licensed Practical Nurse (LPN);
☐ Home Health Aide services;
☐ Homemaker services;
☐ Companion services;
☐ Speech, occupational or physical therapy,

Please provide supporting documentation for care received. If 65 or over: (Medicare Summary Notice or Home Health Plan of Treatment)

Important - 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, 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 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 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 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 benefit 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: _____

If this document is completed by a Power of Attorney, please attach a copy of that document.
In the event the insured is deceased, we will require a copy of the Certified Death Certificate.

By signing this document I attest to the accuracy of its content as well as confirm I have read and understand the above statement that may be applicable to my state.

For the sake of obtaining information, I hereby authorize any physician, hospital, clinic, company or person having any records, data or other information concerning me or my dependents to furnish such records, data, or information as may be requested by HARTFORD LIFE INSURANCE COMPANY, HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY, or their duly authorized representative. A copy of this authorization shall be as valid as the original.

PLEASE ATTACH COPY OF ITEMIZED HOSPITAL BILL, UB92 OR MEDICARE SUMMARY

Please return the completed claim form set to us, along with all the required documentation. In addition, an Authorization to Release Medical Information form is included with this claim form which is to be used in the event we need to contact the Doctor(s) as shown above or on the Attending Physician's Statement.

ATTENDING PHYSICIAN'S STATEMENT - SHORT TERM RECOVERY - GROUP

Patient's Name | Age

Address (Street, City, State & Zip Code)

Diagnosis and Concurrent Conditions, PLEASE INDICATE THE PRIMARY DX OR CAUSE FOR HOSPITALIZATION FIRST.
(If Fracture or Dislocation, describe Nature and Location)

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.)

Nature of surgical procedure, if any.

CPT Code | Date surgery performed

Give dates of other medical (non-surgical) treatment, if any.

Office _____ _____ _____ _____
Home _____ _____ _____ _____
Hospital _____ _____ _____ _____
Nursing Home _____ _____ _____ _____

Is patient still under your care for this condition? ☐ Yes ☐ No If "no," give date your services terminated. _____

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No If "Yes," explain.

Has patient been treated for this illness/injury in the past 12 months? ☐ Yes ☐ No If "Yes," give date(s)

Date(s) of Treatment _____ _____ _____ _____

If performed in hospital, give name of hospital. _____

☐ Inpatient ☐ Outpatient

Signature (Attending Physician) | Degree

Address (Street, City, State & Zip Code)

Telephone
( )

Date

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 or type*)	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 dat a 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 or Guardian	Date	Relationship to Insured (*if signed by Guardian*)

[1] The Hartford® is The Hartford Financial Services Group, Inc., and it's subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, and Hartford Life and Accident Insurance Company, and administrative services companies Hartford-Comprehensive Employee Benefit Service Company and Specialty Risk Services, LLC , and any of their parents, affiliates, subsidiaries and/or third-party contractors.