Group Business Travel Accidental Death & Dismemberment Claim Form for Employee

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Employer and Employee/Beneficiary, as applicable.

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms. Also, please read the "Important Notice" on page 3.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Group Business Travel Accident Benefits.

Part I - Employer's Statement

- ☐ Form is to be completed in its entirety and signed by the Official Representative of the Employer/Plan. If this is a death claim, a certified Death Certificate stating cause and manner of death must be attached to this form.
- ☐ Proof of salary as defined in the Policy (attach W2 or commissions, if applicable)
- ☐ Submission of claims on any voluntary or contributory AD&D plans must include copies of the enrollment forms and history to show timely enrollment.
- ☐ All claims must be submitted, along with the beneficiary designation forms then on file with the Employer/Plan, if any. If none on file, the Employer/Plan shall certify to that fact on the claim form.

Part II- Beneficiary Statement

- ☐ If more than one beneficiary, each beneficiary can either sign and date one form, or each can complete separate forms, showing their current address(es), date(s) of birth and Social Security Number(s).
- ☐ Your signature on the Medical Release of Information Authorization.

Part III- Claimant's Statement

- ☐ Must be completed by claimant or beneficiary alleging any death or dismemberment due to an accident.
- ☐ Additionally, please furnish any newspaper accounts, police or motor vehicle reports, autopsy/toxicology, Trip itinerary and other pertinent information regarding the claim for accidental death or injury.

Part IV - Attending Physician's Statement **(needed for Dismemberment/Sight/Hearing/Speech claims ONLY)**

- ☐ Attending Physician should complete pages 7 and 8 for above losses.

Miscellaneous - All Claims

- ☐ If the claim proceeds are payable to an Estate, Executors or Administrators of the Estate, Part II and/or III must be completed by an Executor or Administrator. An official certificate of such person's legal appointment and qualification must be attached to this form. Please include the Estate Tax Identification Number. If none available, please explain.
- ☐ If any designated beneficiary is a minor, Part II and/or III must be completed by a custodian or guardian. An official certificate of the guardian's legal appointment and qualification of the minor's estate or property must be attached to this form, if applicable.
- ☐ Foreign Death -- Include both the Official Death Certificate and the Death of American Citizen Abroad form.

Release of claim forms is not an admission of coverage under a policy for an employer, group or organization.

The Hartford
Group Life/AD&D Claims Unit
P. O. Box 2999
Hartford, CT 06104-2999
1-888-563-1124

Group Business Travel Accidental Death & Dismemberment Claim Form for EMPLOYEE

Clear Form

PART 1 - Employer's Statement

Group Policy Holder/ Employer Name:	BTA Policy Number:	Location #
Name of Insured Employee/Participant	Date of Birth / Age	Social Security Number
Address (Street, City, State and Zip Code)	Telephone Number ( )	Employee Class #

Employee's Annual Salary as defined in policy: $ _____ (Attach W-2, if applicable) ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually Does this amount include overtime, commissions or bonuses? ☐ Yes ☐ No Effective Date of above Reported Salary _____ Month/Day/Year Date employee last physically reported to work: _____ Month/Day/Year	Amount of **Employee's** Principal Sum In Force Business Travel $ _____ Has amount indicated above been reduced due to age reductions on the policy? ☐ Yes ☐ No **Note:** Changes in amounts of coverage, or increases in coverage, may not apply if the employee was absent from work due to illness or injury on the effective date of the change or increase. Changes or increases are deferred until the employee returns to active full-time work. Is Employee Actively at Work? ☐ Yes ☐ No If "No," reason:	Amount of **Employee's** Principal Sum being claimed: Business Travel $ _____ Has amount indicated above been reduced due to age reductions on the policy? ☐ Yes ☐ No **Note:** Changes in amounts of coverage, or increases in coverage, may not apply if the employee was absent from work due to illness or injury on the effective date of the change or increase. Changes or increases are deferred until the employee returns to active full-time work. Please describe the Business Trip and Purpose for this employee. Please include dates.
Reason employee did not return to work:	☐ FMLA (provide approval form)	Was claim for Long Term Disability or Waiver of Premium ever approved? ☐ Yes ☐ No
Date of death or injury: _____ Month/Day/Year	Employee's full-time employment: From: _____ Month/Day/Year To: _____ Month/Day/Year	Occupation of Deceased/Injured:
Is Employee a U.S. Citizen? ☐ Yes ☐ No	Date of Retirement: _____ Month/Day/Year Date of Termination: _____ Month/Day/Year	Are there any absolute assignments on file? ☐ Yes ☐ No If "Yes," explain:

Is a Beneficiary Designation Card on file? ☐ Yes ☐ No If "Yes," a copy must be submitted.

Employer Certification: *I hereby certify that the information provided on the Employer Statement is true and complete according to the records of the Employer. I agree that this information is subject to audit by Hartford Life Insurance Company or Hartford Life and Accident Insurance Company and/or its representative.*

Dated: _____ Address: _____
(Street, City, State and Zip Code)

_____ By: _____
(Employer) (Their Authorized Representative) [Please print].

_____
(Signature)

( ) _____ ( ) _____
Telephone Number Facsimile Number)

IMPORTANT NOTICE

For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Virginia and Puerto Rico: 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.** (In Oregon, a fraudulent insurance act may be 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, and New Mexico: 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."

For residents of Louisiana: 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 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 Puerto Rico: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For residents of Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposeof defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To: _____ or any employer, benefit plan, insurer, 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 5 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, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and 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, bank records; business transactions billing, invoices, payment records, and academic transcripts; 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 under my employer's benefit plan. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, unless action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

I ALSO UNDERSTAND that once My Information has been disclosed to The Hartford, as permitted under this Authorization, it may be re-disclosed 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 any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; or e) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers my employer's benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any claim system of 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 or legal services related my claim; (vi) as may be lawfully required; (vii) as I may further authorize, or (viii) as may be necessary to prevent or to detect perpetration of a fraud.

I 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 of the policy or benefit plan. 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, Guardian, or next of kin /	Relationship to Insured (*if signed by other than Insured*)	Date

[1] The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, and its administrative services company Hartford-Comprehensive Employee Benefit Service Company, and any of their parents, affiliates, subsidiaries and/or third-party contractors. Also as used herein, The Hartford provides insurance or claim administration services to my employer's employee welfare benefit plan(s).

The Hartford
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PART II - Beneficiary's Statement

Federal Law	Federal Law requires us to give you this information. We may have to withhold and send to the IRS 31% of certain reportable payments you may be entitled to. We will not have to withhold this amount if we have your correct Social Security Number, and you state that you have not been notified that you are subject to an IRS back-up withholding order on interest and dividends.

Name of Deceased: _____ **Policy #(s):** _____ **Claim # (if known)** _____

By signing below:

(1) **I Hereby Certify and Agree** that I have not been notified by the Internal Revenue Services (IRS) that I am subject to a back-up withholding on Interest and Dividends. (If you have been so notified, cross out this statement "(1)." Provide your initials and today's date next to the cross out marks).

(2) **I Hereby Certify and Agree** that I have read and understand the IMPORTANT NOTICE on page 3 of this claim form package.

(3) **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.

Safe Haven Account

If your claim is approved and exceeds the current applicable minimum set by the Company, an interest-bearing draft account will be opened for you, and you will promptly receive your personalized drafts. You may immediately utilize all or a portion of those funds by writing your drafts against that account. The funds in the account will earn interest.

Arkansas, Colorado, Florida and Nevada Residents Only - in order for a SAFE HAVEN ACCCOUNT to be established the beneficiary **must** select the option as noted below. ***Failure to select the SAFE HAVEN ACCOUNT will result in benefits being issued in a one-time lump sum settlement.***

☐ SAFE HAVEN OPTION - I wish to participate in the SAFE HAVEN ACCOUNT enrollment. Please forward the appropriate materials to allow me to access my life insurance proceeds.

It should be noted there could be a lengthy delay in the issuance of life insurance proceeds should insolvency of the Hartford occur.

MEDICAL RELEASE AUTHORIZATION

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates, or information concerning the deceased or injured's occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, HIV, and alcohol/drug records to release all such records in their entirety to Hartford Fire Insurance Company, Hartford Life and Accident Insurance Company, Hartford Life Insurance Company and any affiliate of any one or more of these companies (collectively and severally, the "Company"). I understand that I may receive a copy of this authorization, and that this authorization is valid for the entire duration of this claim, and that I may revoke this authorization at any time by sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to the employer, regulatory state agency, or Workers' Compensation carrier.

BENEFICIARY INFORMATION

Beneficiary Name (print): _____ Date of Birth: _____

Mailing Address:

X _____ Date: _____
(Signature)

Social Security Number: _____
or Tax/Estate ID

Telephone Number: ( ) _____

Beneficiary Name (print): _____ Date of Birth: _____

Mailing Address:

X _____ Date: _____
(Signature)

Social Security Number: _____
or Tax/Estate ID

Telephone Number: ( ) _____

Beneficiary Name (print): _____ Date of Birth: _____

Mailing Address:

X _____ Date: _____
(Signature)

Social Security Number: _____
or Tax/Estate ID

Telephone Number: ( ) _____

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PART III - Claimant's Statement of Accidental Death or Injury

INSTRUCTIONS: Complete this form if you are applying for death or dismemberment benefits due to an Accident. If a question does not apply, please mark "N/A."

GROUP POLICYHOLDER/EMPLOYER NAME:

Name of Insured Employee/Participant	**Social Security Number**	**Policy Number(s)** BTA _____	Age:

Has a Workers' Compensation claim been filed? ☐ Yes ☐ No If "Yes," what is the staus of the claim?

On what date did the accident happen? _____

Where did the accident happen? City _____ State_____ Country _____

Did accident result in death? ☐ Yes ☐ No If "Yes," on what date?_____

Describe in detail how the accident happened:

Name and address of law enforcement agency involved *(Please submit copy of Police Accident Report and/or provide Case #)*

List name/address/phone # of all physicians consulted for this injury/death:

List name/address/phone # of all hospitals consulted:

Did the deceased/injured have any chronic disease or physical defect or deformity? ☐ Yes ☐ No If "Yes," describe in detail:

Was autopsy performed? ☐ Yes ☐ No If "Yes," provide name/address/ telephone number of coroner, if known.	Was an inquest held? ☐ Yes ☐ No If "Yes,' verdict?

Name of Beneficiary	Address:(Street, City, State and Zip Code)	Telephone Number ( )	Date:

Your date of birth: _____ In what capacity are you making claim? _____

(Note: if other than beneficiary, attach appropriate legal documents substantiating your authority.)

Your address _____ and

telephone number ( ) _____ (if different from beneficiary):

Your relationship to deceased or injured: _____ Your Social Security Number: _____

Please sign and date the authorization.

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates, or information concerning the deceased or injured's occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, HIV, and alcohol/drug records to release all such records in their entirety to Hartford Fire Insurance Company, Hartford Life and Accident Insurance Company, Hartford Life Insurance Company and any affiliate of any one or more of these companies (collectively and severally, the "Company"). I understand that I may receive a copy of this authorization, and that this authorization is valid for the entire duration of this claim, and that I may revoke this authorization at any time by sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to the employer, regulatory state agency, or Workers' Compensation carrier.

SIGNATURE OF PERSON COMPLETING THIS FORM	DATE:

Dismemberment Filing Only

PART IV - Attending Physician's Statement
Dismemberment - Loss of Sight/Hearing/Speech

Please print - Use a separate sheet of paper, if necessary

Patient's Name	Date of Birth	Social Security Number

Address	City	State	Zip Code

On what date did you first examine and treat the patient for this injury? _____ Where? _____

Had patient previously had medical attention for this injury? ☐ Yes ☐ No If "Yes," by whom?

Describe the injury and its affected body part(s).	Date of injury

What complications, if any, have arisen?

What surgery was performed?	Date of surgery

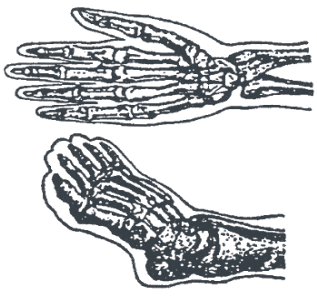
Name of Surgeon

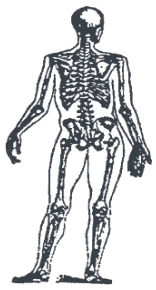
Name and address of Hospital	From: _____ To:	Was the injury described above, of itself, and independent of all other causes, sufficient to require amputation? ☐ Yes ☐ No

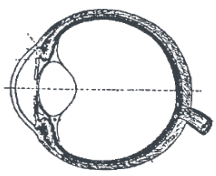
Was the injury described solely responsible for the loss? ☐ Yes ☐ No If "No," give the particulars of any contributing cause or causes?

Was claimant under the influence of alcohol and/or other drugs at the time of the accident or injury? ☐ Yes ☐ No ☐ Unknown

Please indicate location of amputation or area of injury, adding any necessary comments on chart provided.





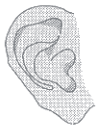


Please indicate best corrected visual acuity and/or area of injury as of _____ (Date).

Right eye:	_____	Corrected	_____	Uncorrected
Left eye:	_____	Corrected	_____	Uncorrected

Is this loss of sight (due to injury) irrecoverable?
☐ Yes ☐ No

PART IV - Attending Physician's Statement Dismemberment - Loss of Sight/Hearing/Speech



In your medical opinion, has this patient sustained complete and irrecoverable hearing loss due to an injury?

☐ Yes ☐ No ☐ Right ☐ Left ☐ Both

Please provide copies of auditory test results.

In your medical opinion, has this patient sustained complete and irrecoverable loss of speech due to an injury?

☐ Yes ☐ No

Please provide copies of speech test results.

Physician Name (please print)			
Street Address	City/Town	State/Province	Zip Code
Facsimile number	Telephone number	Taxpayer's Identification Number	
Physician's Signature	Specialty/Degree		Date

Please return completed form(s) to:

The Hartford
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Facsimile: 1-866-344-9747