CRITICAL ILLNESS BENEFIT

Clear Form

Claim Forms for Employee or Dependent

THE HARTFORD

EMPLOYER'S RESPONSIBILITY

1. Complete, sign and date the **Employer/Policyholder Statement** below.

2. Verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly.

3. Submit the Employer Statement directly to:

SEND THE CLAIM FORM TO:
The Hartford Critical Illness Department
P.O. Box 99906
Grapevine, TX 76099

OR FAX TO:
1-469-417-1952

For questions about how to complete this form, call
1-866-547-4205

IN FURNISHING THIS FORM THE HARTFORD® DOES NOT WAIVE ANY OF ITS RIGHTS OR DEFENSES NOR ADMIT LIABILITY

EMPLOYER/POLICYHOLDER STATEMENT

Employer Name:			Policy Number:	
Name of Insured Employee:			Social Security Number:	Date of Birth:
Insured's address: (Street, City, State & Zip Code)				
Branch/Location:	Occupation:	☐ Salaried ☐ Hourly	If Hourly, number of hours worked per week?:	Date of Hire:	Date Last Actively at Work (if applicable):

If not Actively at Work, provide reason employee did not return to work on their next scheduled workday:

☐ Illness ☐ FMLA (provide approval form) ☐ Retirement - Date: _____ ☐ Other (please explain): _____

Claim is for (check one):		Employee's Critical Illness Benefit Amount in Force:
☐ Employee	Effective date of employee's coverage: _____	$ _____
☐ Dependent of Employee	Effective date of dependent's coverage: _____	

EMPLOYER CERTIFICATION

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

Name of Employer:	Telephone Number of Authorized Representative: ( )
Address of Employer: *(Street, City, State & Zip Code)*	
Certified by their Authorized Representative: *(Please print)*	
Signature of Authorized Representative:	Date:

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CRITICAL ILLNESS BENEFIT
Claim Forms for Employee or Dependent

THE HARTFORD

EMPLOYEE'S RESPONSIBILITY

1. Complete, sign and date the **Insured Employee Statement** pages 2 through 3.

2. Read and sign the Important Notice, page 4. Also sign and date the Authorization, page 5.

3. Remove the Attending Physician's Statement, pages 6 and 7, from this form package and give to claimant's physician certifying the condition claimed. Be advised that claimant is responsible for any fees charged by the physician for completion of this form. Claimant's physician must complete the forms and return within 10 business days to:

SEND THE CLAIM FORM TO:
The Hartford Critical Illness Department
P.O. Box 99906
Grapevine, TX 76099

OR FAX TO:
1-469-417-1952

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INSURED EMPLOYEE STATEMENT

Employer Name	Full Name of Insured Employee	Social Security Number	Date of Birth

This claim is for: ☐ Self ☐ Spouse ☐ Dependent Child

If claim is for Dependent Child, is the child over the Policy's limiting age? ☐ Yes ☐ No

If Dependent Child over the limiting age, is child disabled? ☐ Yes ☐ No Full-time student? ☐ Yes ☐ No
If Dependent Child is full-time student, if required by the Policy, please include Enrollment verification from school.

Name of Claimant	Social Security Number	☐ Male ☐ Female

Citizenship: ☐ U.S. Citizen ☐ U.S. Resident ☐ Non-resident Alien

Claimant's Date of Birth

Claimant's Address	E-Mail Address

Telephone Number: Day ( ) Evening ( ) Mobile Phone Number ( )

TYPE OF BENEFIT BEING CLAIMED

- ☐ Cancer Benefit
- ☐ Coronary Artery Bypass Graft
- ☐ Bone Marrow Transplant
- ☐ Heart Attack
- ☐ Heart Transplant
- ☐ Stroke Benefit
- ☐ Kidney Failure Benefit (includes transplant)
- ☐ Major Organ Transplant
- ☐ Occupational HIV Benefit
- ☐ Coma Benefit
- ☐ Paralysis Benefit
- ☐ Loss of Sight Benefit
- ☐ Loss of Hearing Benefit
- ☐ Loss of Speech Benefit
- ☐ Hospital Benefit - Complete Hospital Benefit section, page 3.

Have you applied for Portability under this policy? ☐ Yes ☐ No If Yes, when: _____

INFORMATION ABOUT YOUR CONDITION

Describe your medical condition

Date of Diagnosis	Date first treated for this condition	Have you ever had the same or similar diagnosis? ☐ Yes ☐ No

If this is a recurrent condition, please indicate treatment date(s)

Were you hospitalized for this condition? ☐ Yes ☐ No

Have you received a payment for this same condition under this plan? ☐ Yes ☐ No If Yes, please explain:

For another condition? ☐ Yes ☐ No If Yes, please explain:

Please continue on next page and sign the Claimant Certification section

THE HARTFORD

INSURED EMPLOYEE STATEMENT - Cont.

Full Name of Insured Employee _____ Employer Name _____

INFORMATION ABOUT CLAIMANT'S PHYSICIAN(S) AND/OR HOSPITAL(S)
List all physicians you have seen for this condition (attach a separate sheet if needed)

Physician's Name | Specialty | Treatment Dates

Address

City/State/Zip Code | Telephone Number ( ) | Fax Number ( )

Physician's Name | Specialty | Treatment Dates

Address

City/State/Zip Code | Telephone Number ( ) | Fax Number ( )

Physician's Name | Specialty | Treatment Dates

Address

City/State/Zip Code | Telephone Number ( ) | Fax Number ( )

INFORMATION ABOUT CLAIMANT'S HOSPITAL STAY (Complete if claiming Hospital Benefit)
Enclose a copy of the itemized hospital bill, including diagnosis, admission and discharge dates, with your claim.

Name of Hospital | Date Admitted | Date Discharged

Address

City/State/Zip Code | Telephone Number ( ) | Fax Number ( )

Describe nature of illness requiring hospital confinement

Claimant Certification

I hereby certify that the information provided in this Statement of Claim form is true and complete to the best of my knowledge and belief.
I Hereby Certify and Agree that I have read and understand the IMPORTANT NOTICE on page 4 of this claim form package.

Claimant's Signature _____ Date (mm/dd/yyyy) / /

Please provide the enclosed Attending Physician's Statement, pages 6 and 7 from this form package, to the claimant's treating physician. Treating physician will need to certify the condition claimed in order to review your claim for benefits.
Be advised that claimant is responsible for any fees charged by the physician for completion of the Attending Physician Statement.

Please read and sign the Important Notice on page 4. Also read the Authorization to Obtain and Disclose Information form on page 5 and sign in the space provided. The authorization will help us obtain any additional information needed to complete our processing of your claim. Failure to sign this form may delay the processing of your claim.

IMPORTANT INFORMATION

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

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, 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 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 _____

THE HARTFORD

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/Claimant or Guardian	Date	Relationship to Insured/Claimant (*if signed by Guardian*)

STATEMENT OF CLAIM
FOR CRITICAL ILLNESS BENEFIT

THE HARTFORD

STATEMENT OF ATTENDING PHYSICIAN

Patient's Name	Date of Birth	Social Security Number

What is the condition causing this patient to be ill? Please provide the diagnosis, ICD Code(s) and subjective findings.

When did symptoms first appear?	Date patient was informed of diagnosis:	Date you were first consulted for this condition:	First treatment date	Last treatment date

Frequency of treatment: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____

Has Patient ever had same/similar condition prior to this occurrence? If so, list related diagnosis and dates of treatment:

Dates unable to work: From: _____ To: _____ Anticipated return to work date: _____

Has condition affected the mental capacity of the patient? ☐ Yes ☐ No

If "Yes," is the patient still capable of managing his own affairs? ☐ Yes ☐ No

Your patient has requested a Critical Illness Benefit, to qualify for this benefit, the patient must have a critical illness diagnosis. Please complete only the section that corresponds to the specific critical illness for which your patient hasbeen diagnosed.

HEART ATTACK

Are EKG changes consistent with Myocardial Infarction?	☐ Yes	☐ No
Were Cardiac Enzymes elevated above generally accepted laboratory levels of normal (elevated DK-MB isoenzyme fraction or elevated troponins)?	☐ Yes	☐ No
Were imaging tests such as nuclear imaging or echocardiogram consistent with a myocardial infarction?	☐ Yes	☐ No
Did myocardial infarction occur during a clinical procedure?	☐ Yes	☐ No

CORONARY ARTERY BYPASS GRAFT

Was the Coronary Artery Bypass Graft recommended by a cardiologist and/or performed emergently?	☐ Yes	☐ No
Was the surgery performed in the USA?	☐ Yes	☐ No

BONE MARROW TRANSPLANT

Was the bone marrow transplant determined to be medically necessary?	☐ Yes	☐ No
Was the bone marrow received from a human donor?	☐ Yes	☐ No

COMA

Is the coma expected to be permanent?	☐ Yes	☐ No
Coma has been present for minimum of 30 days?	☐ Yes	☐ No
Does the coma meet one of the following scales?		
l Rancho Los Amigos Scale (RLAS) as a level I or II	☐ Yes	☐ No
l Glasgow Coma Scale values of 3 through 5	☐ Yes	☐ No
l Disability rate scale with values of 22 through 29	☐ Yes	☐ No
Is the patient on mechanical ventilation?	☐ Yes	☐ No

HEART TRANSPLANT

Heart transplant was medically necessary?	☐ Yes	☐ No
Patient was on a transplant list,such as UNOS?	☐ Yes	☐ No
Was the transplant from a human donor?	☐ Yes	☐ No
Was the transplant performed in the USA?	☐ Yes	☐ No

KIDNEY FAILURE

Is the disease classified as end stage renal disease?	☐ Yes	☐ No
Does the patient require either hemodialysis or peritoneal dialysis on a least a weekly basis?	☐ Yes	☐ No
Does the patient require a kidney transplant?	☐ Yes	☐ No

PARALYSIS

Is there complete and permanent loss of function of 2 or more extremities?	☐ Yes	☐ No
Is paralysis caused by a condition other than a stroke (CVA)?	☐ Yes	☐ No
Is there documented evidence the paralysis was caused by illness or injury?	☐ Yes	☐ No

Please continue on next page and sign the Attending Physician Certification section

STATEMENT OF CLAIM
FOR CRITICAL ILLNESS BENEFIT

STATEMENT OF ATTENDING PHYSICIAN - Cont.

Patient's Name	Date of Birth	Social Security Number

LOSS OF SIGHT

Is the best corrected visual acuity equal to or worse than 20/200 in both eyes?	☐ Yes	☐ No
Is the field of vision less than 20 degrees in both eyes?	☐ Yes	☐ No

LOSS OF SPEECH

Has the patient experienced loss of speech for at least 12 months?	☐ Yes	☐ No
Has the loss of speech been verified by a licensed professional?	☐ Yes	☐ No

LOSS OF HEARING

Is the auditory threshold equal to or less than 90 decibels while utilizing a hearing aid?	☐ Yes	☐ No

MAJOR ORGAN TRANSPLANT

Lung and/or pancreas , or liver transplant was medically necessary?	☐ Yes	☐ No
Patient was on a transplant list, such as UNOS, or if partial liver transplant from a live donor?	☐ Yes	☐ No
Was the transplant from a human donor?	☐ Yes	☐ No
Was the transplant performed in the USA?	☐ Yes	☐ No

STROKE

Did CVA occur and result in paralysis lasting more than 24 hours?	☐ Yes	☐ No
Is there evidence of measurable objective neurological deficits persisting for at least 30 days post CVA?	☐ Yes	☐ No
Stroke was NOT diagnosed for cerebral symptoms due to migraine, or cerebral injury resulting from trauma or hypoxia or vascular disease affecting the eye or optic nerve or vestibular functions?	☐ Yes	☐ No

OCCUPATIONAL HIV

Was the HIV a direct result of exposure during the course of the patients normal occupation?	☐ Yes	☐ No
Was the initial HIV test completed within 24 hours of exposure and produced a negative result?	☐ Yes	☐ No
Was a follow up HIV test taken between 90-180 days and the result positive?	☐ Yes	☐ No
Was the appropriate exposure protocol followed in accordance with prudent workplace and any applicable legislation, regulations or guidelines?	☐ Yes	☐ No

CANCER

Is the patient HIV +?	☐ Yes	☐ No
Is the cancer considered to be either benign, dysplastic, an intraepithelial neoplasia, a pre-malignant growth, a non melanoma skin cancer, or a melanoma in situ classified as a TisNOMO?	☐ Yes	☐ No
Does the cancer require surgery, radiotherapy and or chemotherapy?	☐ Yes	☐ No
Is the cancer considered terminal, with death expected within 24 months or less from date of diagnosis, and has exhausted curative therapy?	☐ Yes	☐ No
Is the specific cancer staged as either:		
l Prostate stage 1b or c, 2, 3, or 4, or a Gleason Scale of 7-10?	☐ Yes	☐ No
l Is the specific cancer staged as thyroid stage 2,3 or 4?	☐ Yes	☐ No
l Is the cancer a carcinoma in situ classified as TisNOMO?	☐ Yes	☐ No

Physician Information

Physician's Name: _____ Social Security Number or EIN: _____

Address: *(Street, City, State, Zip Code)* _____

Specialty: _____ License Number: _____ Telephone Number: ( ) _____ Fax Number: ( ) _____

Physician Signature: _____ Date: _____

MAIL TO:
THE HARTFORD CRITICAL ILLNESS DEPARTMENT
P.O. BOX 99906
GRAPEVINE, TX 76099

FAX TO:
1-469-417-1952