RESERVE OFFICERS ASSOCIATION

THE HARTFORD

Health Insurance Claim Form

Before completing, please read all instructions carefully to insure fast, accurate processing.

INSTRUCTIONS ON HOW TO SUBMIT A CLAIM FORM

1. The form must be completed with all requested information, and sign and date the reverse side of form.
2. Complete Section 2 **only** if you want us to pay your insurance benefits to the provider (for example, doctor, clinic, hospital, etc.)
3. Enclose a copy of your TRICARE Explanation of Benefits form. Put your certificate number on the copy.
4. For TRICARE Supplements, if services were provided in a Civilian Hospital, please attach a copy of the TRICARE Explanation of Benefits Form; if services were provided in a Government Hospital, a copy of your Subsistence Receipt is needed; If you have TRICARE Prime Coverage, please submit a copy of your bill showing amount of charges and also the copayment amount.
5. If your claim for benefits is under the Hospital Income Plan, send a copy of the hospital bill showing of admission and discharge dates.
6. Mail Claims to: Reserve Officers Association
   P. O. Box 10403
   Des Moines, IA 50306-0403

Section 1 - Claimant's Statement (Please, only one patient per form)

Insurance number as shown on your ID card and schedule of benefits billing notice: 020-

Name of Member (Last, First , Middle Initial):

Date of Birth:

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

Telephone Number: ( )

Email Adress:

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

Name of Patient:

Date of Birth:

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

Gender: ☐ Male ☐ Female

Relationship to Member: ☐ Spouse ☐ Son ☐ Daughter ☐ Other

Have you claimed benefits for this condition previously? ☐ Yes ☐ No If yes when? ____________

Diagnosis or Description of Condition:

Section 2 - Assignment of Benefits (Complete this section only when you wish payment to be made directly to the provider's of service. If more than one provider, list each one on a separate piece of paper.)

Provider's Name:

Provider's Telephone Number: ( )

Provider's Address: (Street, City, State & Zip Code):

Section 3 - Need Help? Have Questions? Call ( ) ____________

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Your Signature:

Date:

In the majority of cases, the information contained on this form is all that is required to process a claim. In some cases, additional information is needed, requiring the claimant to complete and submit a more detailed form.

[1] The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

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, 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 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.

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.