INSTRUCTIONS ON HOW TO SUBMIT A CLAIM FORM

1. **The form must be completed with all requested information. Please sign and date pages 3 and 4 before returning.**

2. **Enclose a copy of the hospital bill or discharge summary showing admission and discharge dates, along with the number of days charged room and board. Your Medicare EOB or UB 04 (from the Hospital) would also be acceptable documentation.**

3. **If claiming benefits under the Recovery Benefit, enclose proof of the plan of treatment approved by Medicare or TRICARE and the explanation of benefits and bills showing each date of service that home healthcare was received.**

4. **Mail Claims to: Mercer Consumer, a service of Mercer Health & Benefits Administration LLC**
   Attn: Claims
   P.O. Box 9326
   Des Moines, IA 50306-9326

Clear Form

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 _____

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 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 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 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.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

To: Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, 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, and to communicate telephonically or electronically with The Hartford's representatives about, any and all of the following personal, private, 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 medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all 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 by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and/or leave request and/or request for accommodation. 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 restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); 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, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any 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, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) 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, respond to regulatory complaints, 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 Authorized Representative	Date (Valid for 2 years)	Relationship to Insured (*if signed by Authorized Representative*)

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