

**HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY  
STATEMENT OF CLAIM FOR SHORT TERM RECOVERY**



**INSURED MEMBER - FILL IN THIS PORTION COMPLETELY  
INSURED'S STATEMENT**

Certificate Number \_\_\_\_\_

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

Primary Insured's Name	Birthdate (Mo. Day Yr.)	Sex	Phone Numbers Home (     ) _____ Office (     ) _____	Claim is for <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
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Address: Street and No. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's Name if other than Primary	Birthdate (Mo. Day Yr.)	If claim is being filed for an eligible dependent, give dependent's insurance effective date. _____
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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 and address of attending physician:
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Has the patient had the same or similar condition during the 12 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 12 months prior to confinement, please include your primary care physician.

NAME	ADDRESS	TELEPHONE NO.	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 12 months prior to confinement:

NAME	ADDRESS	TELEPHONE NO.	PERIOD CONFINED
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____

**Complete for Claim of Recovery Benefit(s).**

Dates for which 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)  
If less than 65: (Physicians Plan of Treatment)

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

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**For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana 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 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 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 purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

\_\_\_\_\_  
**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, & if shown).

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 \*- HOSPITAL INCOME PLAN - GROUP OR INDIVIDUAL**  
**Required only if claim date of service is within 12 months of insured's effective date of coverage.**

Patient's Name _____	Address _____	Age _____
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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 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 Date \_\_\_\_\_  
 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  Out patient

Signature (Attending Physician) \_\_\_\_\_ Degree \_\_\_\_\_

Street Address \_\_\_\_\_ City or Town \_\_\_\_\_

State or Province \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_ Date \_\_\_\_\_

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION  
HARTFORD LIFE INSURANCE COMPANY  
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY



\_\_\_\_\_  
Name of Claimant

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies who has provided payment, treatment or services to me or on my behalf within the last 10 years,

Any past or present employer;

Any group insurance policyholder, insurance contract holder, insurance company or reinsurance company, benefit plan administrator, claims administrator that has provided payment, treatment or services to me or on my behalf within the last 10 years and Insurance Services Office, Inc.,

I have filed a claim for insurance coverage under a group life, accidental death and dismemberment and/or disability income policy issued by Hartford Fire Insurance Company, Hartford Life Insurance Company and/or Hartford Life and Accident Insurance Company. This Authorization is intended to comply with the requirements of §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") effective April 14, 2003. However, by signing this Authorization, I understand that Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Accident Insurance Company and their affiliates, employees, representatives and agents (collectively "Hartford") are not subject to the requirements of HIPAA. Hartford will use information received in accordance with this Authorization for the purpose of evaluating and administering claims for group life, accidental death and dismemberment and/or disability income benefits.

By signing this Authorization, I authorize you to release and disclose to Hartford, a complete copy of any and all health information, including but not limited to x-rays, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes (collectively, "Health Information"). For purposes of this Authorization, Health Information specifically includes confidential information regarding HIV/AIDS; sexually transmitted diseases and communicable diseases, alcohol or drug use, and treatment of mental illness but excludes psychotherapy notes as defined by HIPAA .

By signing this Authorization, I acknowledge and agree that any agreements I have made to restrict disclosure of my Health Information do not apply to this Authorization and I authorize any person or entity identified above to release and disclose my complete medical file without restriction.

By signing this Authorization, I acknowledge that I understand the following:

- That any Health Information disclosed under this Authorization may no longer be protected by the federal privacy standards under HIPAA and may be re-disclosed without the knowledge of any person or entity authorized to disclose the Health Information. Note that Hartford will only use Health Information obtained under this Authorization for the purpose of evaluating and administering claims for group life, accidental death and dismemberment and/or disability income benefits, including obtaining reinsurance and conducting legal and business activities that relate to such claims. Hartford will only disclose Health Information obtained under this Authorization in accordance with its Corporate Privacy Policy.
- That my claim for benefits may be delayed and/or denied if Hartford is unable to obtain Health Information necessary to properly assess my claim because I do not properly sign, date, and deliver this authorization or any person subject to HIPAA that receives it does not comply with it.
- That, if necessary, Hartford will send this authorization to persons or entities authorized to release Health Information about me. I have a right, at any time, to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will not be effective to the extent that action has been taken in reliance upon this Authorization or Hartford otherwise has the right to contest the policy or claim under the policy.
- That this Authorization will expire two (2) years from the date of my signature below.
- That a photographic copy of this Authorization shall be as valid as the original and I am entitled to a signed copy of this Authorization.

\_\_\_\_\_  
Signature of Claimant or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority or Relation to Insured (Required if signed by Personal Representative)